

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
TUESDAY, 1 MAY 2018**

SESSION TWO

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 10.26 am**Dr MEGAN BEST****Palliative Care Physician and Academic, examined:**

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson. I am the Chair of the joint select committee. We have Mr Simon Millman; Hon Dr Sally Talbot; Mr John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; Mr Reece Whitby; and Hon Robin Chapple.

The committee has agreed to invite you to attend today because when Rev Margaret Court of Victory Life Centre gave evidence in March, she indicated that the submission had relied extensively on your academic work and recommended we hear directly from you. You have agreed to provide evidence to the committee. Your evidence is protected by parliamentary privilege in Western Australia and protected by uniform defamation laws in Australia against actions in defamation. Please note these protections do not apply to anything you might say outside of today's proceedings. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing.

Do you have any questions about your attendance today?

Dr BEST: No. My questions about Skype have been answered; thank you.

The CHAIR: Good. Did you want to make an opening statement for the committee?

Dr BEST: I would, thank you very much. Thank you for this opportunity to address the committee.

Personally, I have been very concerned about the amount of misinformation that has been presented in our national debate on euthanasia, which is not making your job any easier in working out what is best for Western Australia. I would like to briefly comment on the public discourse. At the heart of the euthanasia debate is a conundrum, because for over 2000 years it has been a prohibited medical practice but now a law has passed in Victoria to legalise euthanasia and assisted suicide, and the debate continues across the country. It is worth considering why we are having this debate now, at a time when we have more medical cures than ever before in human history. Why is this debate occurring primarily in developed countries? The timing suggests it is not a failure of medicine that has prompted the debate.

I have been engaged in this debate for nearly 30 years and I have found that there is a lot of confusion in the public about what euthanasia is actually is and what a change in the law would entail. I define "euthanasia" as an act where a doctor intentionally ends the life of a person by the administration of drugs at that person's voluntary and competent request for reasons of compassion. It is a decision made voluntarily by the patient with no coercion involved, they are mentally competent at the time and the doctor's act is intentional. I prefer to keep the definition narrow and assess each end-of-life scenario on its own merits. I define "physician-assisted suicide" as the situation where a doctor intentionally helps a person to commit suicide by providing drugs for self-administration at that person's voluntary and competent request. So, in that situation a doctor is distanced from the act, but morally it is no different to euthanasia as the motivation,

intention and outcome are the same. I note that generally bills that allow assisted suicide will also allow euthanasia if the patient is physically unable to self-medicate.

It is also important in this debate to realise what euthanasia is not. Euthanasia is sometimes confused with stopping treatment that aims to prolong life, because in life-threatening illness treatment initially aimed at cure may become futile; that is, it stops working, or is so burdensome, due to distressing side effects like vomiting, that any benefit from the treatment is no longer worthwhile. At this point, the treatment may be no longer prolonging life so much as prolonging the process of dying. So, at this time a decision may be made with the patient to stop such a treatment. This practice is not euthanasia, because the intention is not to kill the patient but to allow the underlying disease to take its course and full supported care will remain in place so the patient is kept comfortable. In the same way, taking someone off life support is not euthanasia. It is not flicking the switch that kills the patient; it is the underlying disease that does it, and that is why they were on life support in the first place.

[10.30 am]

Another situation which is often confused with euthanasia is adequate symptom control in the terminally ill. Very occasionally in the terminal stages of disease, the distressing nature of a patient's symptoms may require the careful sedation of the patient while seeking to preserve their dignity. It is not euthanasia because the intention is not to kill the patient but to alleviate their distressing symptoms. Now, some people would call this practice of symptom control "passive euthanasia" because of a myth in the community that the use of morphine necessarily shortens the life of the patient. They argue that if we already practice that type of euthanasia, why can't we have the other type of euthanasia using lethal injection, which they call "active euthanasia". You see the problem. The morphine myth has been around for years, and we do not seem to be able to squash it. That is a shame because it makes people scared to use what is really an excellent treatment for pain, but in fact morphine in therapeutic doses does not shorten life. Indeed, it may actually prolong life. An Australian study showed there was increased survival in palliative care patients on high doses of morphine, probably because they were more comfortable.

Some people would also say that we starve patients to death in palliative care units, but this is just a misunderstanding of the normal metabolic changes which occur at the end of life. Patients stop feeling hungry, and indeed they would not put on weight even if we did feed them, as we know from our experience in the 1980s when we tried it. Forcing patients to eat at the end of life increases their discomfort, so we do not do it. Stopping futile and burdensome treatment and maintaining adequate symptom control are good medical practice at the end of life and should be encouraged in clinically appropriate situations. They do not constitute euthanasia. Euthanasia is not the same as palliative care. The goal in palliative care, as the World Health Organization states, is neither to hasten nor defer death. When the public has a better understanding of end-of-life care, it reduces the call for euthanasia because there is less suffering experienced along with an increased sense of control for the patient. The majority of deaths in palliative care are peaceful; however, I am sure you have heard from people who have witnessed terrible suffering at the end of life, as indeed I have myself. It should not happen but it still does, even in the most progressive institutions. We need to do more about care of the dying, and we can talk about that later if you like.

But here we need to turn to the problem of suffering itself. We know from jurisdictions where euthanasia is legal that physical suffering is an unusual reason for a euthanasia request. Problems of a psychological or existential nature are the usual reasons why people want to hasten death. The prospect of one's own death raises existential questions that are difficult to face in our youth-obsessed and death-denying society. My own research has shown that this type of existential

suffering can indeed be treated, but such treatments are not widely known or practiced. Many people fear death, and they want to control it in any way they can. The only way you can control death is by choosing the timing and manner by which you die. Also the incidence of depression is high in terminally ill patients, and up to 80 per cent of depressed patients with cancer are not diagnosed or treated. A wish for hastened death is a symptom of depression, which is a treatable disease. When most people want to hasten death, we call it a psychiatric emergency and we worry about the rising rate of suicide in our country. Why are the terminally ill treated differently? Why isn't this a psychiatric emergency? The legalisation of euthanasia sends a message to our society that suicide is a legitimate solution for trouble in life. The youth suicide rate in Western Australia is at an all-time high. Is this the message we want to send? I worry about my patients and the pressure they will be under to ask for euthanasia when they do not really want it if the law is changed. We know that all euthanasia laws internationally have been subject to abuse.

You have a choice: to make euthanasia available for the small number of people who want to choose the timing and manner of their own death; or you can choose to protect those people at risk of dying when they do not really want to, if a law is passed. Personally, I do not think that government exists to support the autonomy for the few at the cost of the security of the vulnerable. Mahatma Gandhi said, "The calibre of a society lies in how it treats its most vulnerable members."

In conclusion, while I oppose euthanasia I suggest the main call for euthanasia comes from a desire for autonomy in our society. We live in a democracy, and my only request, if you decide to recommend euthanasia, is that you separate it completely from medical care and leave doctors to care for patients without the spectre of hastened death hanging over us. Thank you.

The CHAIR: Thank you very much, Dr Best. I think the committee members have questions.

Hon ROBIN CHAPPLE: Thank you, Dr Best. Your evidence mirrors very much what we have heard in terms of the end-of-life process. We have had some very, very good information around that. So, yes, we are sort of on the same page there. We had a witness yesterday—Dr John Haines, a Palliative Care WA member—who in referring to the Netherlands example said that the statistics on end-of-life treatments used in the Netherlands were that 25 per cent died from the withdrawal of treatment, 25 per cent received terminal sedation, and 50 per cent the so-called double effect. He then went on to say that dying patients in palliative care are provided with the same service, and therefore we did not need voluntary assisted dying. That indicates to me that he has actually made the statement that currently we are using the dose of double effect and the dose of terminal sedation within palliative care, yet we hear from yourself that that is not the case. Can you separate the two arguments for us?

Dr BEST: So he is claiming that 50 per cent die from the principle of double effect from morphine; is that what he is saying?

[10.40 am]

Hon ROBIN CHAPPLE: He did not actually attribute it to any particular medication. He just said that 25 per cent received terminal sedation, and 50 per cent were the so-called dose of double effect.

Dr BEST: Okay. That is certainly not my own experience so I cannot answer for that. I do not know where he works and I cannot answer for his unit, but I would say that in the unit where I most recently worked, where we would have about 600 admissions a year, maybe two or three per year would have terminal sedation. It is certainly nothing like 25 per cent. If you are saying people die from withdrawal of active treatment, basically they die from their underlying disease and that is certainly what I think the majority of people would die from. I do not think the principle of double effect applies to morphine and sedatives if they are given in therapeutic doses close to the end of

life, which is the customary timing. There is definitely no evidence that morphine shortens life if it is used in therapeutic doses.

Now, I do know that some doctors use large doses of morphine with the intention to end life, and I think they need to be reported to the healthcare complaints commission for negligent practice. The principle of double effect would work for things like chemotherapy where you intend to cure the cancer, but the effect of reducing the immune status of the patient puts them at risk of infection and they might die that way. But I certainly object to the idea that morphine used in therapeutic doses requires the principle of double effect to explain how it works. I certainly do not think people die of therapeutic doses of morphine, and I can give you many references which would support that position.

Hon ROBIN CHAPPLE: The evidence we heard is to that same effect—that morphine is not a pathway itself. But we have heard of the administration of other drugs in the whole process of the end of life in palliative care, where other drugs are given where morphine is not suitable.

Dr BEST: Yes, different types of pain require different pain medications.

Hon ROBIN CHAPPLE: Yes.

Dr BEST: Morphine is also very good for breathlessness. Sometimes it is used in that setting if someone has no pain, but they are the two main indications.

Hon COLIN HOLT: Thanks for joining us. I think at the end of your statement there—I am going to paraphrase—you said, “If you introduce a framework for euthanasia, please leave the medical professional out of it so that they can go on and care for their patients.” Can you expand on that a little bit and maybe give your views on how you would see a legalised framework operating without the medical profession involved?

Dr BEST: It is starting to happen in the jurisdictions where euthanasia is legal because an increasing number of medical practitioners do not want to be involved with the hastening-of-death practice. But basically I believe the main push for euthanasia in our society is a call for autonomy. I think there are a lot of people who are very scared of dying at the end of life and they do not have the vocabulary to talk about the existential distress that they feel. We hear many stories about the terrible things that happen at the end of life and they are scared. If you talk to some of the baby boomers who are currently well but sort of looking ahead, they worry that they will be kept alive when they are incompetent and they worry about loss of dignity, and they want more control over what happens at the end of life. That is why I think there is a push that if you just legalise euthanasia for people who have only six months to live, then that is not wide enough because people want to have more choice.

We have people who have debilitating illnesses who want a longer time frame so that they do not have to go through the last stages of their diseases. I think that in a society that has lost touch with the meaning of suffering there is, understandably, a loss of the willingness to endure suffering. There are some people who want to avoid going through the process of dying completely and just go from being relatively well to being dead, without having to go through the dying process. In places like Holland, the criteria for accessing hastened death is the standard of suffering, which is not defined and is subjectively determined. It is not related to terminal illness. You have people there who say, “If I think I am suffering, I should be able to access hastened death.” It is not about a failure of medicine. As I said, we have better palliative care than ever before. In my own career, there has been an exponential improvement in palliative care. So at this time where we can do so much for people who are dying, we have the loudest call for assisted death. I think it is about autonomy—people wanting to be able to control their death. If we then say we do not have to jump through

medical hoops in order to say whether you are going to die in six months, 12 months or 18 months, and just say that if you really want to access hastened death, and you are mentally competent and not coerced, you can have it. Putting an injection into a vein is a relatively simple procedure that anyone can learn, so you could just have assisted-death clinics in the community and people who wanted it could go book themselves in and be assessed and get the injection if that was what they wanted. You do not have this conflict of doctors who have given an oath to protect the welfare of their patients being put in this difficult situation, where on the one hand we are trying to cure people, and on the other hand we are told that we have to assist people in their death. I wonder how you would feel if your profession was suddenly told you were the ones who will have to administer the assisted death, when you never signed up for it in the first place. So I think that we should recruit people who are very enthusiastic about assisted dying and who have no professional conflicts of interest and are therefore the ones who will operate this procedure. I often think that perhaps we should have journalist-assisted suicide rather than physician-assisted suicide, because as a group they are more enthusiastic.

Hon COLIN HOLT: I wonder if I could just bring you back to the point you made a minute ago about potential clinics and open slather, I guess, would be a way to describe it. Checks and balances? How would you see checks and balances working in a situation like that?

Dr BEST: The same checks and balances as you have now with the current proposed legislation, in that you would make sure someone is mentally competent, that it is a voluntary decision and they are not under any pressure. If we are saying it is about autonomy, then it is a personal decision for consenting adults. We are told by the pro-euthanasia lobby that not many people will want to access it, so I think that it bypasses the conflict with medical ethics and still allows people in the community who want this practice to be open to them to be able to access it safely.

The CHAIR: On the role of doctors, we had evidence from the AMA in WA which indicated that if legislation for voluntary assisted dying were introduced, a majority of doctors should be involved. Do you have a comment on that?

Dr BEST: Can you give me more background on that?

The CHAIR: That was evidence from the president of the WA AMA—that doctors surveyed thought that doctors should be involved.

Dr BEST: I do not know the background of that and the reason why, which is obviously an important thing to understand that comment. I was talking to a palliative care colleague from Belgium at a conference last year. In Belgium, basically you access euthanasia through palliative care doctors. The reason he agreed with that process was because he knew that a lot of the people who thought they wanted euthanasia would change their mind once they had experienced palliative care, and by having euthanasia through palliative care doctors they would get a chance to experience palliative care and see what was possible before they made the ultimate decision. The current guidelines in legislation, that people have to be told about palliative care, I think are basically useless because until you experience it, people do not truly believe what can be done. One thing I noticed from this Belgian doctor's comments was that he personally was experiencing a great degree of moral distress in having to be involved with the euthanasia act. He said it was affecting a lot of his colleagues as well. To be practising palliative care and administering euthanasia was extremely difficult, with a high psychological cost for that group of doctors.

[10.50 am]

The CHAIR: I have another question in relation to palliative care. We are running short on time so I am trying to get through as many questions as possible and move to my colleagues. We have

received evidence of some really harrowing and horrific suffering where medications are being titrated appropriately over a long period of time. Is that suffering really justified when a higher dose would alleviate it?

Dr BEST: It is not being titrated properly if it is not relieving pain, or it is the wrong drug, or you are dealing with existential suffering, which needs a completely different treatment. I am not saying that palliative care is going to solve everyone's concerns about end-of-life care, but certainly if it were more widely spread we would have a lot less distress in the community.

Hon Dr SALLY TALBOT: Dr Best, thanks for your opening statement. We have actually already read most of that material because Margaret Court included it all in her submission to the committee. You said in that opening statement and that document that when the public has a better understanding of end-of-life care, it reduces the call for euthanasia. Where is your evidence for that?

Dr BEST: The evidence is that we know that over half of the patients receiving palliative chemotherapy—that is, chemotherapy which is not aimed at cure—think that they are receiving it for curative intent, and they are experiencing side effects because they think the benefit is worthwhile. But it is obvious that a lot of people are pursuing palliative interventions at the end of life at a cost to themselves when they are not actually aimed at cure. We have a lot of people in the community who do not realise that they actually have a choice to stop treatment which is not aimed at cure because of the burden of side effects. In my own practice, time and time again I have seen people who did not realise that they could stop treatment if they wanted to and be more comfortable, and rather than spend their time in hospital spend their time at home with the dog. Even looking at the book of stories of suffering from *Go Gentle—I think it was called The Damage Done*—there are examples in that of people who suffered because they continued with treatment which they had the opportunity to stop but continued partly because they felt it was aimed at cure, and sometimes because family members are scared of losing the person who is dying and may urge them to continue with chemotherapy which is ultimately futile in purpose.

Hon Dr SALLY TALBOT: You will be familiar with the evidence this committee has heard. We have heard from a lot of people who want to access end-of-life options that are not currently legal. I have not been persuaded that any of them would change their minds if they were better informed or better educated. I wonder whether you could —

Dr BEST: Better treated?

Hon Dr SALLY TALBOT: Pardon?

Dr BEST: Would they change their minds if they were better treated?

Hon Dr SALLY TALBOT: No. We have asked the question specifically of a number of them and they have said no. I wonder if you could envisage a situation where the assessment has been done that somebody is not depressed—they might be depressed because they do not want to die but they are not clinically depressed so they would not benefit from antidepressants. They are well informed and have good access to palliative care and yet they still wish to access voluntary assisted dying. What would you say to those people? How would you assess their capacity to make that decision?

Dr BEST: Are you asking me how I would know if they were mentally competent? Is that your question?

Hon Dr SALLY TALBOT: What I am saying is that if you have somebody who is not clinically depressed and has good access to and good support from palliative care services and yet they still wish to access voluntary end-of-life treatment, how would you assess their capacity to make that decision?

Dr BEST: I have already said that I think the main driver of this debate is the wish for autonomy. The example you have just given me is a very good example of that. I think that consenting adults should be able to make self-defining choices. I think the problem with the euthanasia debate is that it is not about what is right for an individual, it is about what is right for the community as a whole. That is when you have to start considering the vulnerable people at risk if the law is passed.

Hon Dr SALLY TALBOT: You have taken us down the slope to a slippery slope argument. You have used a slippery slope argument to present a slippery slope argument. Am I to understand that you are not actually —

Dr BEST: I am sorry. How have I done that?

Hon Dr SALLY TALBOT: If I have understood you correctly, you have said that voluntary assisted dying may be a valid option for some people, but on a community level it is not acceptable because it exposes vulnerable people to risk.

Dr BEST: Yes. I think they are two completely different questions. Is it ever right for an individual? Obviously, if you have a personal way of making ethical decisions where autonomy is of great importance, you can decide, “This is right for me.” But when we decide what is best for the community as a whole, the government is obliged to think of the majority—not of the few.

Hon Dr SALLY TALBOT: Do you see autonomy—the wish to remain autonomous—as a psychological illness?

Dr BEST: Of course not.

Hon Dr SALLY TALBOT: Or a problem for people?

Dr BEST: Of course not, but I think it is not the only value of importance. I think it is a very narrow way of looking at human beings as only autonomous individuals. I think it neglects to realise that we are people in relationships and that we have needs other than being able to make our own decisions.

Mr J.E. McGRATH: Thank you very much, Dr Best. You talked about baby boomers. As a baby boomer, I am very proud to be in that category of Western Australians. My electorate has a lot of baby boomers in it. You said that the baby boomers want more choice and control over their lives. You also said that society has lost touch with the meaning of suffering. I talk to a lot of people about this subject and whenever I raise it, the one response that I invariably get is, “Oh well, the doctors are doing it now anyway.” I go to your comment where you said that some doctors use large doses of morphine to end life and they should be reported. I think that is a very strong statement. What evidence do you have of that, and how widespread would this be? I think a lot of people in the community would think that if someone is suffering and the doctor helps them end their life and they are close to death anyway at the time, they would cope with that.

[11.00 am]

Dr BEST: You have asked several questions there. I said that morphine in therapeutic doses does not hasten death. It is very hard to kill someone who has been taking regular morphine with morphine itself. You would have to give a very big increase in dose. You do not kill people with morphine by accident. We are talking about big, inappropriate doses which can be distinguished from the doses required from normal treatment. We are not saying that we never use big doses of morphine; there will be cases where it is appropriate, but you get there by small increments in dose. You do not jump from nothing to a large dose. I know of at least one case that has gone before the New South Wales medical board where a doctor was found guilty of doing that and was treated accordingly.

I have been told by Dr Philip Nitschke, who I have publicly debated on many occasions, he said that approximately 1 000 people a year are killed in Australia. I asked him where he got the evidence for

that and he could not tell me, so I have hearsay. I do not personally know of any cases where it has happened and I certainly do not do it myself. I think we need to find the line between treating people appropriately for their symptoms but not allowing this inappropriate over-dosage of morphine, which is designed to treat pain and breathlessness. It is not a sedative and it is not designed to end life. Doctors, if they do not know how to use morphine properly, they need to learn and I think that if there are people in the community who are not acting responsibly, which is causing anxiety in the community, they need to be disciplined because some doctors are doing the wrong thing.

Mr J.E. McGRATH: Just to the other point that is often raised with me, people seem to be comfortable, if their loved one is in the last few hours or the last couple of days, if their death is assisted, if the family is comfortable with it and they have all said their goodbyes. Do you agree that this might be a sentiment out there in the community?

Dr BEST: If your constituents have said that to you, obviously it is a feeling out in the community. I have not experienced that personally but certainly I have heard some people discuss that that may be an issue. But I also would just like to say that there are some people in the community who think that if someone is on morphine at the time they die, that the morphine was what killed them rather than the underlying disease, and I have done a lot of talkback radio where that definitely is a misunderstanding of end-of-life care in the community. So I think you would have to unpack it to know what they are actually saying. Are they saying, “I’m glad this person received the pain relief they needed at the end of life”, or do they honestly think that if you are on morphine when you die, you got killed by the morphine? Both those beliefs exist in the community.

Hon ROBIN CHAPPLE: Thank you, Dr Best. Reiterating almost what you have just said, we have heard that morphine as a particular drug would not be a drug that would be used in most cases to create terminal sedation or unconsciousness.

Dr BEST: No.

Hon ROBIN CHAPPLE: The evidence that we are hearing is that if people are assisted at the end it is not through morphine. I really —

Dr BEST: There was a case in New South Wales where it was, but yes.

Hon ROBIN CHAPPLE: Other drugs quite clearly are available—Diazepam and other things—which can actually assist in creating a state of unconsciousness, creating a state of sedation. Whether we use the terms “terminal sedation” or “palliative sedation”, it is clearly not morphine. I am interested in why you are focusing on morphine.

Dr BEST: Because of many years talking to people in the general public as I try to start them on morphine medications for pain or breathlessness in the palliative care setting. There are fears in the general public about commencing morphine. This is something that is well documented in the palliative care population in Australia—that people bring into the palliative care consulting rooms many fears about morphine, which affects our ability to treat them. This is well known by anyone who works in palliative care for any length of time in Australia—that these morphine myths exist.

Hon ROBIN CHAPPLE: Exactly.

Dr BEST: They are not questioned at all and I can provide research papers to show you the incidence of this belief.

Hon NICK GOIRAN: Dr Best, you have given a lot of evidence this morning about what you have referred to as the “morphine myth”. I think it has been the most valuable and probably best explanation that we have had of that myth from the various witnesses that we have had. I take it that that morphine myth in effect would not be limited just to morphine, following on from the

question from my colleague Hon Robin Chapple. If family members see a family member dying at the end of life having been injected with some other drug—morphine or otherwise—and that is the last thing they see happen, I take it then that that myth can be extrapolated out to those other drugs as well?

Dr BEST: Absolutely. It is just human nature. You see an injection, someone stops breathing. It is understandable that someone might think that they were connected, but most of the drugs we would use at the very end of life with someone whose body was slowing down, generally I think it would be very surprising if they had time to actually take effect, because at the end of life in palliative care we put a little needle under the skin. We do not put it straight into the vein because just under the skin, a subcut needle, is much more comfortable for the patient. It takes a longer time for those drugs to absorb. I think it is a visual thing that I understand people deciding, but in fact it is very unlikely that a subcut injection would cause an immediate stopping of breathing.

The CHAIR: Thank you very much for joining us today, Dr Best, and for your evidence before the committee. A transcript of this hearing will be forwarded to you for correction of transcribing errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by 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. Again, thank you very much for taking the time to give evidence to the committee today. We really appreciate it.

Dr BEST: Thank you very much.

Hearing concluded at 11.07 am
