

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
WEDNESDAY, 28 FEBRUARY 2018**

SESSION FIVE

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 3.29 pm.

Dr ELIZABETH MOORE

Branch Chair, Western Australian Branch, Royal Australian and New Zealand College of Psychiatrists, examined:

Ms ZOE CARTER

Policy Officer, Western Australian Branch, Royal Australian and New Zealand College of Psychiatrists, examined:

The CHAIR: Thank you both for joining us this afternoon. 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. I will introduce the other committee members. We have Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Col Holt; Hon Nick Goiran; Reece Whitby; and Hon Robin Chapple.

The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. Do you have any questions about your attendance here today?

The WITNESSES: No.

The CHAIR: Before we move to our questions, would you like to make a brief opening statement?

Dr MOORE: Yes, thank you. The Royal Australian and New Zealand College of Psychiatrists is a membership organisation. Within WA, we have about 450 members. Being a membership organisation and part of the community, this debate around end-of-life choices has raised a number of different issues for the college. The college agrees with the AMA point of view that it is the ethical duty to care for dying patients so that death is allowed to occur in comfort and with dignity. This requires service options and resources. The main thrust of our submission to yourselves was that there should be palliative and mental health services appropriately resourced, and especially in line with the lack of some of the basic resources outside of the metropolitan area, looking at both palliative care and aged care, as well as mental health services. In order to make this legislation, if it goes ahead, reasonable, realistic and doable, we are recommending that there be a clinical reference panel that is able to assist with that legislation, should it go ahead. The college itself has considered that we need to allow people to make their own choices about their end-of-life decisions, but the question of capacity is a very complex one, and the community needs to make this decision regarding the legislation.

The CHAIR: With regard to treatment at end of life, would you consider the current laws and healthcare practices are adequate for the care and treatment of patients around the end of life?

Dr MOORE: One of the main areas that we can add to this debate is around mental health. To support healthcare practices for end-of-life choices, we want to again come back to the resources implication. There are current gaps in services, both in consultation and liaison psychiatry, and in culturally-appropriate care. We feel that services need further support in decision-making and

consent issues around advance health directives, especially looking at care options, not only palliative care but also the other end of the spectrum, aged care, so looking at the service options that are available to people as they age that may actually make different decisions.

The CHAIR: I think I am hearing that the everyday practices of palliative care, terminal sedation and palliative starvation, are not within your remit.

Dr MOORE: Correct.

The CHAIR: With regards to voluntary assisted dying, in your view is it possible to distinguish temporary suicidal ideation from an enduring, considered and rational decision to end one's life in the face of unbearable suffering, in circumstances where VAD would be legally available?

Dr MOORE: I believe so, in most cases. A person's mental state can alter their decision-making, be that if a person has a mental illness, a depressive illness or a psychotic illness, that will alter their decision-making capacity. But there are also physical symptoms that can alter a person's decision-making ability, for instance, people who are not receiving adequate nutrition. We know that people who weigh less than 40 kilograms—obviously as adults—have a more rigid cognitive structure, which makes some of their decision-making different to that which they would make if they were fully physically aware. There are also environmental symptoms. I think there has been a couple of cases being put forward to the committee around the change of circumstance—people going into nursing homes and feeling quite demoralised or possibly depressed. That comes again back to our resourcing implications. If nursing home care was more adequately resourced, would that feeling of desperation be less?

Mr J.E. McGRATH: With regard to people with mental illness, what sort of safeguards would you want to see put in place to make sure that those people were not caught up and were able to make a decision that really they should not have been allowed to make? How can we make sure that does not happen?

Dr MOORE: If you are looking at palliative care, I think that the assistance of a psychiatrist within the palliative care team is really important. I think the committee has heard from Lisa Moore, who is one of our psychiatrists. Her passion is around palliative care, and the difference a psychiatrist can make within the palliative care team. That is not only in the assessment of the person with mental illness, but also in those other factors that may lead one to think that the person has a mental illness.

Mr J.E. McGRATH: Further to that question, what about in non-palliative care areas? One of the issues that has been raised with us is that people who are not in palliative care, but for some reason or other want to end their life, feel they should be entitled to do so. That could also involve people who have got some sort of mental condition that has put them into that state of mind. Do you see that as a big issue, going forward?

Dr MOORE: I see that as an issue, but with the correct safeguards. Obviously that person would need to be assessed. We would suggest that if there was any reason to think that that person's balance of mind was affected, they would be referred to a specialist psychiatrist for that assessment. I think it is really important to recognise that psychiatrists do capacity assessments all the time under the Mental Health Act. This, of course, would be a slightly different area, but we have expertise in that area.

Mr J.E. McGRATH: One further question: are you aware of psychiatrists being involved in other jurisdictions around the world that have brought in the right for people to make a choice about their end of life?

Dr MOORE: I am not, but I could take that question on notice.

Hon Dr SALLY TALBOT: I think I heard you say, in your response to Mr McGrath, that if there was any doubt about a person's capacity, they should be assessed. So you do not see that assessment of capacity as necessarily having to be done by the psychiatrist in the first instance?

Dr MOORE: The college position statement also looks at specialist capacity assessment by other specialists, for instance, palliative care specialists. For such a difficult area, though, I would think that most medical practitioners would want to seek a specialist capacity assessment.

Mr R.R. WHITBY: In terms of capacity, do you believe that it is possible for someone with mental illness to still have the capacity to make a decision on an end-of-life choice?

Dr MOORE: I do. There is a stigma around mental illness, but capacity is actually contextual. The elements around capacity are the ability to understand the condition, the ability to understand the treatment options, to weigh up those options and then communicate that decision back to a person. For instance, we have people with mental illness who get married.

They have the capacity to make that decision to get married. We have people with mental illness who have physical illnesses and they have the capacity to make those treatment decisions, in some cases—in most cases. Around end-of-life choices, obviously, there would have to be a degree of scrutiny of that because it is such a difficult and permanent decision.

[3.40 pm]

Hon ROBIN CHAPPLE: My impression really comes down to: are there types of mental condition that would preclude capacity and are there ones, by their very nature, that include capacity? I am not asking for an exhaustive list, but it would be interesting to know if you could say, "This person with this type of condition could not ever have capacity to make the decision, whereas these people with these conditions could."

Dr MOORE: Capacity itself is very contextual; it is around an individual decision. It is around those different elements that you are asking people to have capacity around. The only ones would be a permanent cognitive impairment. I would have to take advice from my Older Adult colleagues around things like dementia, where you would consider that, but you would still have to do a capacity assessment for that individual decision, that decision-making capacity.

Hon NICK GOIRAN: Dr Moore, the question that you were asked by the Chair talked about distinguishing temporary suicidal ideation from an enduring, considered and rational decision. How would you assess "enduring"?

Dr MOORE: You would have to obviously assess over a period of time. The time frame is obviously of the essence if you have somebody that is terminally ill who wishes to end their life. But it is a matter of looking at, I would say, previous advance health directives, assessing that capacity either serially or through a number of different specialists, and also speaking with families and carers who may know the patient's wishes themselves.

Hon NICK GOIRAN: The question also asks you in circumstances where voluntary assisted dying is legally available. Voluntary assisted dying, you are probably aware, is not a term of reference for this committee.

Dr MOORE: Yes.

Hon NICK GOIRAN: And indeed an attempt to even include the word "euthanasia" in the terms of reference was not supported. Nevertheless, there has been a lot of questions about this topic, as you can imagine. Are you able to define for us what you understand to be "voluntary assisted dying"?

Dr MOORE: We put it in our submission. If you will bear with me, I will get the exact wording. We called it physician assisted dying or physician —

Hon NICK GOIRAN: Are we talking about the same thing?

Dr MOORE: I believe we are.

Hon NICK GOIRAN: Okay. Define to us what “physician assisted dying” is.

Dr MOORE: It refers to situations where doctors prescribe, but do not administer, lethal substances to informed patients who have a terminal illness or a grievous and irremediable medical condition and have the legal capacity to decide that they may end their own life at the time of their choosing.

Hon NICK GOIRAN: It is where the practitioner is not involved in the act?

Dr MOORE: Correct. Euthanasia is when the practitioner is involved in the act.

Hon NICK GOIRAN: What is voluntary assisted dying in all of that, then?

Dr MOORE: I believe that is physician assisted dying.

Hon NICK GOIRAN: Or physician assisted suicide?

Dr MOORE: We tend not to use the term “physician assisted suicide”.

Hon NICK GOIRAN: Even though you do in your submission at page 2 of 11. I quote —

PAS is sometimes also called ‘physician assisted dying’, ‘physician assisted death’ or ‘physician aided dying’.

Dr MOORE: That is the complexity around the whole area.

Hon NICK GOIRAN: For everybody, including committee members. I asked a similar question earlier this afternoon to the Chief Psychiatrist. I do not have the transcript of that, but as best as I can recall he described physician assisted suicide as involving the practitioner, but voluntary assisted dying as not involving the practitioner. Obviously, hence the difficulty when you have two learned psychiatrists talking about the same topic but using different terminology.

Dr MOORE: It is one of the functions of the committee to come up with a consensus statement!

The CHAIR: Very good.

While we are talking about capacity, have you had an opportunity to look at the Chief Psychiatrist’s submission and his evidence to this committee?

Dr MOORE: No, I have not.

The CHAIR: He states that a psychiatric assessment for capacity should be mandatory for anyone seeking a voluntary assisted suicide, physician assisted suicide, or death. What is your view on that?

Dr MOORE: The college’s view is that that recognises that psychiatrists do have an area of expertise in this, but we have included in our submission, and the college’s position statement also includes, capacity assessments by other trained professionals.

The CHAIR: Who might they be?

Dr MOORE: Palliative care physicians and geriatricians generally speaking, so specialists.

The CHAIR: We have also had some commentary that there are not enough psychiatrists in Western Australia to meet demand and that to make it mandatory in any model would create logistical issues for getting people into see psychiatrists.

Dr MOORE: Certainly, the Department of Health released information around the number of psychiatrists needed, which was going up exponentially, and the number of psychiatrists expected,

which was not going up exponentially. It would have resource implications. The resource implications that we fear is that it would take psychiatrists away from already needed basic palliative care. The palliative care psychiatrists who are involved in those teams would then have to be diverted rather than expand to cater for capacity assessments.

The CHAIR: My understanding from Dr Lisa Miller's evidence last year was that she is the only psychiatric palliative care specialist.

Dr MOORE: She is double trained, but we do have psychiatrists that do work in consultation liaison services which include palliative care. Once again, the disparity there between metro and rural is quite striking.

Hon NICK GOIRAN: On the issue of assessment of capacity, is it the college's position that if there is a scheme, there are three specialties that would be appropriate to assess capacity—psychiatrists, palliative care specialists and geriatricians?

Dr MOORE: Those are the three that we have suggested, but we have also suggested actually a clinical reference group to guide the legislation. One of the problems—I am not speaking out of turn here—is that the mental health legislation that was recently introduced is somewhat cumbersome. If there was a clinical reference group in line with other reference groups that you may have, you may be able to finesse those actual areas.

Hon NICK GOIRAN: This is an important topic. You are saying that the changes to the Mental Health Act are cumbersome. What aspects of it are cumbersome?

Dr MOORE: The act itself and the lawyers that —

Hon NICK GOIRAN: The act itself is not small.

[3.50 pm]

Dr MOORE: Yes, it is fairly large. It has put an administrative burden on psychiatrists which actually takes away from patient care time. What we would ask is that legislation be obviously cognisant of limited resources but needs to have that oversight role to actually get the result that is required in terms of protecting patient rights without adding an administrative burden.

The CHAIR: The Mental Health Act is relatively recent and was developed over a long period of consultation with practitioners, so what would be different? My understanding is that psychiatrists and mental health practitioners were very much involved in the development of that act, so what would be different in the development of another act?

Dr MOORE: I would hope that with a clinical reference group—perhaps we did not explain the difficulties quite as well as we could—across the various specialties, and perhaps also including pharmacy and palliative care nurses, that the actual processes that underlie the legislation would be able to be explained and streamlined before the legislation came in.

Hon NICK GOIRAN: Is the administrative burden you describe under the Mental Health Act some form of safeguard?

Dr MOORE: The feeling that the clinicians had was that those safeguards could actually be re-engineered—for instance, there is a multiplicity of forms that all have to be filled in to show what you have done—whereas what the clinicians argued for, and it was not felt to be legally appropriate, so it did not go ahead, was a form that showed the progress of a patient through the legal process. It sounds small, but those changes in trying to find different forms, filling them in and putting them in the file actually makes a big difference to the amount of time that people can take.

Hon NICK GOIRAN: There was advice given that that was not legally —

Dr MOORE: That was not appropriate.

Hon NICK GOIRAN: It immediately makes me think: What would be different now? We are still in the same jurisdiction. If that process was not appropriate under the Mental Health Act—where, can I say, we have the worst case scenarios where you are involuntarily detaining someone, but they are still alive—how much more so in a circumstance where the stakes are higher?

Dr MOORE: I think the best way to answer that is that I know that legal opinion differs and that perhaps there would be a different legal opinion about this particular act should it go ahead.

Hon NICK GOIRAN: I have got more questions about capacity but I think you are getting there.

The CHAIR: Are you aware of any patients requesting assessment of their capacity by a psychiatrist in Western Australia in order to facilitate physician-assisted suicide or dying in another country?

Dr MOORE: No; we have not been made aware of any.

The CHAIR: I want to take you back a step to some of the terminology. You said that your organisation was very careful not to use the word “suicide” versus “death”. Can you expand on that for me, please?

Dr MOORE: I think one of the good things about this particular process is that it is actually getting the conversations going around death and dying, similar to the conversations we are now having around suicide prevention. To my mind, it is really important not to conflate the two. Suicide itself is a really complex area. It has been shown in a number of studies that the actual act of suicide—somebody may think about ending their life as suicide—can be quite spontaneous. This gives us a lot of decision points in order to try to alter that person’s perspective. This is a different scenario. When a person is not expected to live for a certain amount of time, that they have unbearable pain or suffering, I think this is a very different scenario from actually saying that the person wants to suicide in the parlance that we are now talking about suicide prevention.

The CHAIR: Do you think legislation that enabled voluntary assisted dying would undermine suicide prevention in the community?

Dr MOORE: No; I do not, not if it is very carefully communicated. I think the communications and the discussions around death and dying—I notice WA Health has now put out an “End-of-Life Framework”, which I have read and I actually think is very good—is changing the culture around talking about death and dying, which really is our last frontier. Death is a part of life. If we as doctors have an ethical responsibility to try to assist people to have a good and dignified death, then we need to have more conversations around death and dying, especially in the cultural aspects of it.

Hon NICK GOIRAN: I think we have opened up a discussion on suicide prevention, so I will go there. What are the risks that need to be mitigated for a person with suicidal ideation?

Dr MOORE: It is very individual in terms of why the person wants to suicide, whether they have access to the means of suicide, and what services and what support services can they actually access which may ameliorate that. There are a number of different reasons why people think of suicide. Some of that is around not feeling that they have any options left. That comes back to our service delivery and resources argument. The other risks are the risks around family and community, so does the family and the community actually openly acknowledge some of the issues that we talk about in suicide prevention so that the person can feel that they can access the services.

Hon COLIN HOLT: You said “access to the means of suicide”. I do not want to be overly crude or simplify it, but where there is a will, there is a way. How do you do that? How do you limit access to the ways of committing suicide?

Dr MOORE: As you say, it is very difficult to limit the access, but, for instance, firearms. Since there are fewer firearms around, death by firearm has gone down; whereas in the United States that is one of the easiest methods of suicide.

Hon COLIN HOLT: Our suicide rate is not going down, is it?

Dr MOORE: The suicide rate fluctuates over time. Certainly, if you look at the recent South Australian data, the suicide prevention they have done in rural areas has made a difference to their suicide rate in the rural areas.

Hon COLIN HOLT: That would not be much to do with access to the means; it would be more to do with support services around the person or the other things you do. I am just making some assumptions, obviously.

Dr MOORE: That is part of it, yes. It is also access to means. In the UK when the gas was changed over to a less lethal gas, there was a difference in the suicide rate. It is actually so multi-factorial. That is why it is so difficult to do research into suicide because there are so many factors that go into why a person would wish to die.

Hon NICK GOIRAN: A means that would need mitigating would be the availability of a medication that, if taken, could end one's life?

Dr MOORE: That is one of the means, yes.

Hon NICK GOIRAN: There seems to be some meeting of the minds between the college and the Chief Psychiatrist that whatever the Parliament might decide to do in this space, it should not have a scheme that actively involves a physician at the, dare I say, pointy end of the process, which by implication means that the physician is not there; it is left to the patient, including by way of a prescription of a drug that the patient might need to take. Is that a concern?

[4.00 pm]

Dr MOORE: I think that that needs further exploration. We are talking about a very small cohort of people here.

Hon NICK GOIRAN: Sure.

Dr MOORE: And so other jurisdictions do not have a physician assisting at the death—it may be a trained nurse, for instance. Doctors do prescribe—but we do not generally administer—our medicines. Would this be different? I think it needs further exploration.

Mr R.R. WHITBY: What about the view that doctors have a right to conscientiously object, and then some may be prepared to administer themselves. What would your college's position be on that if a member did that?

Dr MOORE: The college does not have a position on that currently because the legislation is not in place. I do know that in the survey in the UK of those psychiatrists who were in favour of voluntary assisted dying, only half of those said that they would be involved in the process. There is a difference between the philosophical argument for it and actually wishing to be involved.

Mr R.R. WHITBY: Participation?

Dr MOORE: Yes. Part of that is around religious beliefs. Part of it is around strongly-held beliefs that life itself is important and that relief of suffering is the main argument.

Mr R.R. WHITBY: As you mentioned before, a small cohort. You might not need that many physicians to decide that they could be involved.

Dr MOORE: Yes.

The CHAIR: The submission we received from Dignitas claimed that being able to discuss assisted dying in that context actually improved their ability to intervene in suicide and help prevent suicides. Do you have any comments on that?

Dr MOORE: In terms of the patient then feeling that they have options?

The CHAIR: Yes.

Dr MOORE: Yes. Certainly there was a paper—I think Lisa also referred to the paper—around the person wanting to hasten death, but that did not actually lead to the action of dying, of actually hastening death. It comes back to the person not feeling that they have no options.

The CHAIR: You also reference in your submission—it is quite an interesting reference—around Australia's older citizens, those aged 80 and above, are the group most likely to die as a result of suicide. Are you able to identify what is driving suicide, if it is not chronic or debilitating terminal disease, in people over 80?

Dr MOORE: Over 85 is even worse. It is actually around those end of life—loss of a meaningful role; the connection to community; all your friends are dying around you; the changing family dynamics, so becoming more dependant perhaps on family when you have been very autonomous yourself; and really perceptions about loss of dignity and loss of control. We all want to be quite autonomous, but with skilled help a lot of that can actually be addressed.

The CHAIR: I think this is actually a really important point and worth exploring, if this is the group that is most affected by suicide, that options are available for alternatives for those people, other than voluntary assisted dying.

Dr MOORE: Yes.

Mr J.E. McGRATH: Further, I find that a bit alarming that these people are not in palliative care but they are old people and in that age bracket, and, as you said, there are various reasons why they are feeling pretty helpless. Would you see that cohort of people as being people who you think could possibly make use of the voluntary assisted dying—and should they? I am not sure they should.

Dr MOORE: No, I do not, because as my understanding is, voluntary assisted dying legislation was to be looking at those people who were in unbearable suffering and had only a short time to live. With our age of dying actually increasing, the challenge for older people in Australia is actually to live a meaningful life whilst they are ageing. We would, for instance, want them to be assessed for a possible depressive illness, look at their options within a psychosocial context for increasing connectedness, and look at the value to the community of our older folk. The voluntary assisted dying I think needs to be, if it is to come in, for a very defined group.

Mr J.E. McGRATH: Which is what has happened in Victoria.

Dr MOORE: Yes.

The CHAIR: Advance care planning, in your view, will the current system for advance care planning be improved by a central register—advance healthcare directives?

Dr MOORE: The problem with a central register is the actual updating of it. Advance healthcare directives can change rapidly over time. If you have an advance healthcare directive and you actually have a change of heart, you will want to update that immediately. I think it is more around the process of actually discussing advance healthcare directives and knowing where they are logged. The personal eHealth record for instance, if that was made more useful and there was access to that, may be better than a central register.

The CHAIR: I think we are hearing evidence from the medical professionals that the advance health directives themselves are a very clunky legal instrument and do not necessarily reflect the changes and the evolution in someone's healthcare plan. Do you have any comment on how that could be improved or any view on how that could be improved from a legal point of view?

Dr MOORE: Certainly our advance health directives, although they are a legal document, are not legally binding if circumstances change. The Chief Psychiatrist has on his website a little area where—of course, you would try to behave in accordance with the advance health directive, but if there is obviously something there that is glaringly obvious that is incorrect, then you would log that on the Chief Psychiatrist's website for those patients with a mental illness.

Hon COLIN HOLT: Not legally binding if circumstances change. What would some of those circumstances be?

Dr MOORE: For instance, if somebody had made an advance health directive whilst they were severely depressed or whilst they had a psychotic illness and made requests for treatments that were unable to be delivered.

Hon COLIN HOLT: Such as voluntary assisted dying, as an example in the current legislative framework we have?

Dr MOORE: That is currently not in our framework. But, for instance if they wish to have a certain course of treatment that was not evidence based, that would actually be something that would be unethical for doctors to consider.

Hon COLIN HOLT: And the doctors make that decision, "Your circumstances have now changed and I am going to give you that treatment"?

Dr MOORE: The doctor tries to make that decision in accordance with the patient but also with the carers and family.

[4.10 pm]

Hon COLIN HOLT: Have you ever had anyone come to you to talk about capacity and the making of an advance health care directive in terms of maybe challenging the healthcare directive—someone has made a healthcare directive, and a family member says, "We think they weren't capable at that point in time"? Is that a common occurrence or have you come across it?

Dr MOORE: It is not common because the advance health directives in mental health still are not as common as they should be. But, yes, I have had family members ask me to consider, with the patient, an alternative.

Hon COLIN HOLT: So you do not actually assess them for capacity at that point in time, to say, "Actually, I think this healthcare directive is null and void because you were suffering depression or delirium"?

Dr MOORE: It would be nice if the healthcare directives were done in consultation with the doctor, but often they are presented to you, having been done.

Hon COLIN HOLT: It is interesting, because they are a legally-binding document in some respects, yet they can be challenged at one end and you can develop them however you want, it seems.

Dr MOORE: That could be an area that the legislation may consider.

Hon Dr SALLY TALBOT: On a point of clarification, if I could. When you were talking about an advance health directive not being legally binding and that there was a place on the Chief Psychiatrist's website on which you could register the fact that you had not acted in accordance with that, you were talking about people with mental illness?

Dr MOORE: Correct; yes.

Hon Dr SALLY TALBOT: Can I also check with you that it is, I think, the case that there is a capacity assessment to make an advance health directive?

Dr MOORE: There is, yes.

Hon Dr SALLY TALBOT: Are you expressing some concerns about that capacity assessment to make an AHD?

Dr MOORE: What has been happening is the advance health directive is sometimes given to us without the benefit of us being able to assess capacity or to see that a capacity assessment has been made.

Hon Dr SALLY TALBOT: Yes, but for the advance health directive to be a legal document, it has to be witnessed by somebody who says that the capacity assessment has been done. Are you saying that is not the practice?

Dr MOORE: That has sometimes not been done.

Hon Dr SALLY TALBOT: Do you mean it has not been done to a point that you consider effective? It is a legal document, so presumably it is signed in the right places. So, what—the people who sign, the statutory witnesses, are not complying with their legal requirements?

Dr MOORE: We may be slightly talking at cross-purposes.

Hon Dr SALLY TALBOT: I have a feeling we are.

Dr MOORE: Yes.

Hon Dr SALLY TALBOT: We are talking about advance health directives—

Dr MOORE: For people with a mental illness and the advance health directive there, sometimes we are presented with the advance health directive with the patient's wishes without some capacity assessment having taken place.

The CHAIR: Are they different documents to advance health directives generally?

Dr MOORE: I would have to compare.

Hon Dr SALLY TALBOT: I think there is only one form, and it clearly has to be witnessed by somebody who is —

Dr MOORE: Can I take that on notice and I will come back?

Hon Dr SALLY TALBOT: Yes, and we can clarify the question as well. Thank you.

Hon NICK GOIRAN: Dr Moore, if there is a disciplinary complaint against a psychiatrist, can a member of the college give an opinion to the disciplinary board about a fellow member?

Dr MOORE: The disciplinary actions are usually through AHPRA, so the Australian Health Practitioner Regulation Agency. I do not know. I am presuming, yes, because somebody will have to. If there is a disciplinary complaint around a person's practice, there will have to be an examination of that person's practise.

Hon NICK GOIRAN: I would need to ask AHPRA?

Dr MOORE: Yes.

Hon NICK GOIRAN: Perhaps I will leave it at this: have you ever been called upon to give an opinion in a disciplinary manner?

Dr MOORE: No.

Hon NICK GOIRAN: What about in any litigation on medical negligence?

Dr MOORE: No.

The CHAIR: There are no more questions. Thank you for your evidence today before the committee. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or to elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. The committee will write to you with questions taken on notice in the hearing. Thank you both very much for attending today. It is much appreciated.

Hearing concluded at 4.15 pm
