

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 THREE

Members

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

Hearing commenced at 1.00 pm**Dr NATHAN GIBSON****Chief Psychiatrist, Office of the Chief Psychiatrist, examined:**

The CHAIR: Welcome back, Dr Gibson. Thank you very much for agreeing to come back to the committee. We very much appreciate it. 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 inquiry. I will introduce the committee. We have Simon Millman; 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 WA and to highlight any gaps that might exist. It is important you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not extend to anything you may say outside today's proceedings. I advise that the proceedings of today's hearing will be broadcast live within Parliament House and via the internet.

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

Dr GIBSON: No.

The CHAIR: I have mostly exhausted my questions for you but I think other members had further questions that they wanted to explore with you.

Hon NICK GOIRAN: Dr Gibson, at the outset, thanks very much for accommodating the committee. I know last time was a little hectic and for what it is worth, the committee has tried over the course of scheduling these various hearings to accommodate some with 90 minutes and some with 60 minutes. Probably with the benefit of hindsight last time we would have put you in for 90 minutes

Dr GIBSON: It was a challenging discussion!

Hon NICK GOIRAN: Thanks for coming back; it is appreciated. Can I start on the issue of assessing capacity. Would you be able to inform the committee on the level of experience that you think a medical practitioner needs to have in order to be proficient in assessing capacity?

Dr GIBSON: There are probably three components; one is the training; the second is the experience; and the third really is the ongoing professional development in capacity. All medical officers/doctors have some training capacity to start off with, so it is not as if there is no training. With regard to capacity in the context of mental illness or the elderly around dementia, both psychiatrists and older age physicians have extra training and capacity in assessing capacity. As far as experience goes, GPs only intermittently get experience in assessing capacity. In an average day a GP may not be assessing capacity at all. Certainly, in the public sector on an average day, most psychiatrists are considering capacity in some way or other as would most older adult physicians as well. GPs would not be routinely assessing capacity, although it depends on the nature of their practice, of course. As far as ongoing professional development, I think there is not a lot new in capacity but I think being able to go and discuss with colleagues and have, if you like, peer supervision around skills is an important part of professional development. Certainly, older adult physicians and psychiatrists would do that. GPs again may not be regularly doing that with regard to capacity because they have so many other things they need to do.

Hon NICK GOIRAN: An important distinction you are making. You are using a phrase I am not familiar with—older adult physicians. Can you just explain that?

Dr GIBSON: Sorry, geriatricians—specialist physicians dealing with elderly patients, particularly around dementia and other multiple illnesses.

Hon Dr SALLY TALBOT: It is not about the age of the physician!

Dr GIBSON: Sorry. It could be. No, it is not.

Hon NICK GOIRAN: Perhaps if we could take those two then. Would I call them professions—psychiatry profession and then the older adult profession?

Dr GIBSON: They are usually called specialists in their career.

Hon NICK GOIRAN: Yes, those two specialties then. What is the level of training that a psychiatrist receives before they are qualified?

Dr GIBSON: Psychiatrists will usually have worked for a couple of years after they graduate from medicine doing general medical jobs and then they will do five years training to be a psychiatrist. Many end up doing five and a half years or some end up doing six. It depends whether they get through their exams first time et cetera, so it is a minimum of five years extra training.

Hon NICK GOIRAN: On top of the two years?

Dr GIBSON: Sorry on top of the six years medicine, then a couple of years doing general medical jobs as a doctor and then five years training.

Hon NICK GOIRAN: You said five to six years for the extra training, so I will take five, for example; six years of medicine, two years of general; and then five, so 13 years. After that 13 years of education and training, at that point, you would be confident that the person is proficient in assessing capacity?

Dr GIBSON: Yes.

Hon NICK GOIRAN: How would that differ with the older adult practitioners?

Dr GIBSON: The geriatricians, which is their actual name, would have a similar sort of thing. They do six years of medicine, then they would work for a couple of years as a general doctor in hospitals and then they would get on the physician training program. It would take them roughly five years as well. Again, it depends whether they go off and do some research whether it takes them longer as well but it is roughly five years.

Hon NICK GOIRAN: It is a lot of education and training but it is obviously a very important issue to be able to assess somebody's capacity. Could it be the case that two practitioners at that level of proficiency disagree on an assessment of capacity?

Dr GIBSON: Yes. Capacity is decision specific, so it is not about the whole person. Whilst you can follow some templates that assist you with capacity, you still have to use your clinical judgement to analyse the responses the person makes, so there can be some differences of opinion regarding capacity at times.

Hon NICK GOIRAN: I guess the next question then that follows from that is: is it just a difference of opinion or could one of the practitioners have erred in their assessment of capacity?

Dr GIBSON: Even where practitioners do not err, they may give particular weight based on their experience to particular aspects of the responses that are made and where it is a borderline case, for example. Where it is very clear when someone has very severe dementia, there would be very few people that would disagree, if any. Where it is very clear that people have capacity, no one would disagree. It is usually around the borderline cases where someone is on a trajectory of losing capacity and where do you draw the line in the sand. That is where the experts have to try to make

a judgement about that line in the sand. Has it been crossed or not? That is why it is tricky. It is not necessarily about erring; it is about the complexity of that grey zone where you are trying to make that decision at that point.

Hon NICK GOIRAN: If I remember from your evidence earlier and perhaps your submission, you expressed the view that if there was going to be a scheme of assisted suicide in Western Australia, it should only be a psychiatrist that makes that assessment on capacity?

[1.10 pm]

Dr GIBSON: That is right; I have that view. A psychiatrist or equivalent specialist. It might be in the case of an elderly person. A geriatrician might be well placed to consider that as well. Palliative care physicians may at times also be well placed. There are certain specialties that will see this more often than others. For example a general surgeon will not spend much of their time doing this kind of stuff but there are certain specialties that will.

Hon NICK GOIRAN: Yes, okay. I think if I remember your evidence from the last hearing, part of the rationale that you gave for that is because the stakes are higher here, hence the need for the narrow field of individuals who could undertake that assessment.

Dr GIBSON: I think so. Screening is one thing, to have a general sense of whether someone might or might not, but to actually give a full assessment is important. I think I gave the example that under the Mental Health Act to make someone involuntary for 21 days requires a psychiatrist to make that call. For a voluntary assisted dying process, the stakes are potentially higher and therefore why would you water down that process?

Hon COLIN HOLT: I just want to throw something else in the mix here. What about familiarity with the patient? My mum is 91; I reckon she is pretty sharp, I have known her all my life. She goes to the same GP for 35 years and I would suspect these days she is pretty sharp and has the capacity to make some decisions by herself. How do you put that into the mix of some of the definitions, or the line in the sand that you said, or the level of who says she has got capacity or not?

Dr GIBSON: A good capacity assessment will use the resources, the people who know the person and GPs who know the person really well, to assist that and give appropriate weight to the evidence that they might provide. It would not be appropriate in that case for someone to do an assessment without speaking to you, without speaking to the GP. I think that would be critical parts of the assessment. On the flip side sometimes a GP who knows someone for a long time can have particular biases about them. We have these human biases which are normal for us, say, "That is actually normal for them, therefore it is not a problem with their capacity", whereas someone new coming in might say, "Well in fact, it is outside normal." There are two sides of that. One is that it is critical to get the third party information that is relevant to any good capacity assessment. Sometimes that is difficult because the person may not agree, but that is available. The second thing is that people who have known someone for a time can have biases. For example, I know when my grandfather was dementing, my uncles were adamant that it was just him and that he was okay, it was just him; there was nothing wrong with him, yet he was quite significantly demented. People bring their own emotional issues as well. Someone who is outside that can look at both of those aspects and try to make a dispassionate view.

Hon COLIN HOLT: They are not really making those decisions in isolation then, are they?

Dr GIBSON: They should not be. That would be poor decision-making to make those decisions in isolation without good third party information where available.

Hon Dr SALLY TALBOT: Dr Gibson, can I ask you whether the sense in which you use capacity in your submission and in the evidence you have given us to this point, is that different from the way that

some of our statutory provisions refer to legal capacity or full legal capacity? I am talking specifically about the advance health directive specification that legal capacity is called “full legal capacity” in the act. Is that different from the way you are using the term?

Dr GIBSON: The legal precedent view of capacity is very much a legal view based on precedent, I guess. The clinical view is different from some extent and people do not always see eye to eye from a doctor/lawyer perspective in that regard. I guess what I am talking about is a doctor trying to assess capacity in the context of applying a statute that might be there. For example, the Mental Health Act has sections which specify the components of capacity. From a clinical perspective you actually have to apply your clinical judgement to those specific aspects within the statute. It is clinicians looking to meet the requirements of the statute, I guess, in that regard.

Hon Dr SALLY TALBOT: Is the answer to my question yes, that they are two different things, that capacity medically is different from full legal capacity? I am not quite clear what you are saying.

Dr GIBSON: A doctor might feel that someone lacks capacity and the State Administrative Tribunal may say, “Based on the criteria in all the assessments we have, we disagree.” The legal process might disagree from the medical assessment. But the doctors are seeking to try to answer the legal questions, I guess.

Hon Dr SALLY TALBOT: There could be disagreement there —

Dr GIBSON: There could be disagreement there.

Hon Dr SALLY TALBOT: —to hark back to the point being by Hon Nick Goiran.

Dr GIBSON: That is right. It is common. Sometimes doctors will say to the State Administrative Tribunal, “I think this person lacks capacity”, and the State Administrative Tribunal will disagree as a panel.

Hon Dr SALLY TALBOT: Because they apply a different test?

Dr GIBSON: They have to consider the whole picture as well. Technically they are looking at the same information, but they come up with a different perspective.

Hon Dr SALLY TALBOT: Do they consider a broader picture than the medical assessment of capacity?

Dr GIBSON: They consider whatever the statute says. For example, the Mental Health Tribunal has the sections within the act which apply to this state and what the capacity components are. They may come up with a different view. Both are looking at the same statute but are giving different weighting.

Hon Dr SALLY TALBOT: In relation to the voluntary assisted dying where you have said that in your view the capacity should be done by psychiatrists, why have you chosen a narrower view? I am sorry, it is probably not quite the way you expressed it, but if you are saying that the SAT might bring others things into consideration, that is by definition a broader set of parameters. Why would you not go for a broader—it seems to me to be a more encompassing set of criteria.

Dr GIBSON: That is a possibility. What I would say is that the information that would feed into that process, if that was the process chosen, should be a psychiatrist’s assessment. I guess what I am saying is whatever process is chosen from a statutory perspective, the psychiatrist should be the one providing the clinical assessment of capacity. I really did not comment on broader statutory processes about panels or other overarching tribunals that might be involved in this process, but from a clinical process I guess I was making the point that the rigour should come from having a psychiatrist provide the clinical advice.

Hon Dr SALLY TALBOT: I see, so the person would then have the right of appeal to the SAT?

Dr GIBSON: If so chosen by the legislation.

Hon Dr SALLY TALBOT: I am just going to press you on this point a little more because it is important and we have had evidence, which the Chair will raise with you, with a contrary point of view, but I notice for instance that an information sheet put out by the public advocate—it is an FAQ sheet, and under the section, “Do I need to have legal capacity?” there is specific reference to the written opinion of a doctor or other medical/health professional. You want the bar set higher than that for voluntary assisted dying?

Dr GIBSON: Again it is a stakes issue, really. I absolutely agree that for every consideration of capacity unrelated to voluntary assisted dying in the state, it is not up to a psychiatrist to do be able to do that. The stakes may be lower and there are appeal processes in that. But where the stakes are higher in this regard, that is the basis on which I am suggesting.

Hon Dr SALLY TALBOT: I am really intrigued by your use of that term about the stakes being higher. I have to say that in my personal experience the people I know who I have spoken to about voluntary assisted dying and many of the people who are contributing to this inquiry pushing for some sort of statutory change have got some of the most clear-eyed views about death and dying that I have ever encountered. I am curious that you consistently refer to the stakes being higher. For example, I notice that the requirement to have an assessment done of somebody’s decision to procure an abortion does not involve a psychiatrist. Again it is a question of life. Do you have a view on that?

[1.20 pm]

Dr GIBSON: Again, I have not turned my mind to that because there are, obviously, different legal considerations of a foetus. I have not turned my mind to that particular aspect.

Hon Dr SALLY TALBOT: Again, if I can just tell you that for an abortion reference is always to a medical practitioner, not to a psychiatrist. It could include a psychiatrist but it is all medical practitioners.

Dr GIBSON: Again, I think it is about the designation of the foetus. You could get into an argument about whether the foetus represent a life, per se, and then whether you are dealing with the same sort of issue. To be honest, I have not turned my mind to that. But I guess the issue is that you will get a number of people who, as you say, are very clear-eyed about this and have full capacity, and I am guessing that they are the folk you have spoken to because they have had the wherewithal to have that discussion with you. The tricky things comes when you have those grey areas that we spoke about, because it is obviously very easy that if someone has a very clear capacity, an assessment would proceed very, very rapidly in that regard. It is also very easy when someone entirely lacks capacity for a range of—it is a grey —

Hon Dr SALLY TALBOT: Yes, there are extremes at either end. I suppose you are talking about the middle. In the case of somebody like the mother of Hon Colin Holt, could that assessment not be done by a GP?

Dr GIBSON: GPs are good at screening. I think the difficulty with screening is that screening is not the full assessment and you will perhaps miss certain complex cases that are grey. There are a lot of folk in nursing homes and in situations where they lack capacity when decisions—you know, there is lots in the literature about decisions being made where it is unclear whether someone has capacity or not. It is often very easy when someone has clear capacity. The difficulty, as I mentioned earlier, I think, is that unless you actually assess the person fully, you do not know whether they have capacity or not. The example I will give is that someone who has dementia can often, in a very superficial and cursory process, make a very good case for themselves, but unless you really delve deep and explore, and sometimes stress the person a little bit, then you will not actually see the situations in which perhaps they do not have capacity. To answer your question: surely a GP, you are saying, can assess capacity when it is clear that the person has capacity? It is kind of a circular

argument. How do you know the person has capacity until you have actually done the assessment? Post hoc, where someone clearly has capacity, you could say, “Yes, absolutely; they clearly had capacity and a GP could have picked that up.” But at the end, when you say that that was a really tricky one—for the first 30 minutes it was really uncertain whether they had capacity. They were presenting very well, but they started to deteriorate as the process went on. We sometimes see that in psychiatric assessments, when someone can present very well initially but cannot sustain the process; so the longer the assessment goes on they show that they cannot sustain the process and that there are capacity issues. There are issues about how it is done. I think it becomes a circular argument where someone really has capacity; in retrospect it is very easy to say that they have capacity. But where someone has capacity, unless you have actually done the assessment, you cannot say that. I am not trying to be confusing, but I am just saying that it becomes a bit of a circular argument, I think—so unless you actually have the full assessment up front. Again, with abortion, I think that is something you could argue requires a proper assessment of capacity. I guess the issue with abortion is slightly different in that you have a younger cohort of individuals who you would automatically believe in most cases to have capacity. For someone who has a terminal illness, who may be on a lot of medications, who may be in pain, it is a different cohort of people I think that you are dealing with—a cohort whom potentially a large number of them are likely to lack capacity than a cohort seeking abortion, so there are perhaps cohort differences there as well.

Hon Dr SALLY TALBOT: The situation you are envisaging as a psychiatrist is that when you do that assessment of capacity, you are looking for a psychiatric condition that can be treated and then at the end of the treatment, whether the treatment is successful, the person could say, “I’ve changed my mind. I don’t want to access voluntary assisted dying.”

Dr GIBSON: There are two things there: one is capacity and one is mental illness, and they are not quite the same.

Hon Dr SALLY TALBOT: Can you tease out that difference for me, because it is not clear to me what the difference is?

Dr GIBSON: The assessment for mental illness is: Does this person have a severe depression? Does this person have a —

Hon Dr SALLY TALBOT: Which presumably the GP assesses in the case that we have just been talking about.

Dr GIBSON: Yes.

Hon Dr SALLY TALBOT: So if the GP is saying: no evidence of mental illness.

Dr GIBSON: That is where it is, again, a stakes issue, because some depression can be difficult to diagnose in certain cohorts, especially in someone who is on lots of medications, in someone who is perhaps in pain; it can be tricky to diagnose depression. You might have two psychiatrists who have different opinions on that as well. It is not an easy, lay-down *misère* diagnosis.

Hon Dr SALLY TALBOT: I go back to my original proposition to you, which is that this person in whom the GP says there is no evidence of a psychiatric condition or a mental illness, but they have to be referred to a psychiatrist to jump the hoop of competence. The psychiatrist is then looking for a psychiatric illness.

Dr GIBSON: They are trying to exclude a psychiatric illness and they are assessing capacity—both are two different things that are interrelated. Capacity is: Does the person understand the nature of the decision? Can they weigh up the various possibilities? It is those sorts of capacity questions versus mental illness questions, exploring whether they have symptoms of mental illness—two processes; both must happen, and a psychiatrist is well placed to do both.

The CHAIR: On the question of psychiatric assessment and capacity, currently a psychiatric assessment is not required for people to refuse life-sustaining medical treatment, which would have a potentially high stake; nor, is a psychiatric assessment required for a substitute decision-maker to refuse life-sustaining medical treatment, which would result in that person's death. Why are the two scenarios different?

Dr GIBSON: I do not necessarily think the scenarios are so different. I guess this is how things have developed over many, many years. I guess the consideration of a voluntary assisted dying or end-of-life statute of some sort comes at a time now when we have had historical development of these things, like: What is the assessment for an abortion? What is the assessment for a refusal of treatment? They are things that have been in place for many, many years. Suicide or ending your own life carries in some ways a different societal weighting, I guess. I am not sure that it can be seen as absolutely the same as someone who is declining to have further treatment. Having said that, I think it is really tricky when someone declines to have treatment to know whether they may be suffering from depression or not. That can be a very difficult and complex decision. I would expect that when a GP is concerned that they would seek a psychiatric opinion as good professional practice in that regard. I guess what I am saying is that where things are complex, there should already been a referral for specialist clarification capacity and assessment of mental illness—number one. Number two, I guess we are talking about a significant change to our practice, moving towards a situation where people can choose to actively end their lives. In medicine we have always differentiated between those two processes.

The CHAIR: I want to refer to some evidence that we heard earlier this week from Dr Paterson, who is a practising psychiatrist. He was here as part of Doctors for Assisted Dying Choice. We referred to your evidence from last year, that you made it clear that you think a comprehensive psychiatric assessment is essential. We asked him to comment on that. I am going to read out his evidence. Bear with me. It is uncorrected evidence; he has not had an opportunity to review this yet.

[1.30 pm]

He is out of step with every jurisdiction internationally and nationally. The Victorian legislation does not propose it. He is out of step with the Royal Australian and New Zealand College of Psychiatrists who say it should be considered, and he is out of step with the local branch who, as I say, recognise that there are practical logistical problems as to why it is not so. Curiously, Dr Gibson suggests it should be mandatory for voluntary-assisted-dying patients to see a psychiatrist, but not mandatory for patients going through the process of terminal sedation. I am not quite sure why he makes the distinction.

Are you able to comment on that or give evidence there?

Dr GIBSON: Terminal sedation in which you are trying to relieve suffering and reduction of life is a side effect of that. The primary intent is to relieve suffering, so there is a clear difference in primary intent, and I think in medicine we have always differentiated, so I am in step with most medical associations around the world that have always differentiated between actively ending a life versus a secondary effect of the life being shortened in the context of relieving distress. I see that quite separately, as do, I think, all medical associations around the world. I am not aware of situations in which people conflate those two as exactly the same situation. Regarding the issue of being out of step with Victorian legislation or the college of psychiatrists, I guess we are in a situation in which the AMA's position is against voluntary assisted dying, although there is a real mix of opinions amongst its members. We are not dealing with a situation that is cut and dried and agreed upon by the medical fraternity, so in that regard I do not think we can be out of step. I think this is one view amongst many within the medical fraternity. I guess my role I see as advocating for the rights of individuals with mental illness and, number one, to ensure that those people with mental illness are

not discriminated against, and also receive the best possible care, and that is why in that regard for those people who may be suffering from mental illness, the role of the psychiatrist is very important. Does that mean that there may be a lot of people out there who apply for end-of-life assessments who have capacity and, as you rightly say, lay down misere, they have got capacity and did they really need to see a psychiatrist? I plump on the side that we are better to take a rigorous approach and ensure that we do not miss out on those individuals who may have difficult and challenging presentations of mental illness so that those individuals are absolutely able to access the treatment and care that they need. There are logistic issues, I understand, but I am not sure that it would necessarily significantly delay the process for individuals who had capacity who were seeking to access legislation. So, I am really looking at a “first do no harm” to that cohort that really need that assessment. Whether you plump on a psychiatrist or a medical practitioner, if you plump on the side of a medical practitioner, there may be some situations in which someone has a mental illness that is not picked up and not treated, so there may be some cases there. It depends where you actually put the weighting, and I am weighting on the side of a more cautious approach. As I said, I do not think I am out of step with many of my colleagues in that regard. I think there is a multitude of different views. I guess I am trying to make a case for the protection of individuals with mental illness, access to treatment for individuals with mental illness and that in the whole picture there are the rights of people seeking, if the legislation comes in, voluntary assisted dying. There are also the rights of people who may be unwell who need the rigour of assessment. You can argue where you sit the weightings for those and I am sitting that weighting with making sure we do everything we can to catch those individuals with mental illness and assure those people who are seeking that capacity to do so. It is a difference of opinion I think.

Mr R.R. WHITBY: Dr Gibson, do I understand you when you talk about mental illness and capacity that you are concerned with protecting the rights of those with mental illness in that they may have capacity to make a judgement on an end-of-life-choices? So, you are also saying that they have a right; they should not be discriminated against in seeking that option because they have a mental illness. Is that correct?

Dr GIBSON: That is right, and that is where it gets complex. Let us say, for example, that someone has had a long history of depression throughout their life. They develop a terminal illness and they are seeking to access voluntary assisted dying. They may have depression that is well treated, they may still have some grumbling symptoms of depression, but they may still have full capacity despite that. That is why I was saying before that having a mental illness does not preclude you from having capacity. Some people may have active mental illness, but have full capacity and still be able to make a very capacitous decision.

Mr R.R. WHITBY: Would the same go for people with disability where there might be some mental impairment or cognitive impairment? What degree, where do you draw the line there in terms of people whether they have capacity or not?

Dr GIBSON: Again, this gets down to the supported decision-making. Can you make sure that the person gets enough information, understands the information and is able to get support to weigh up those things? Someone who initially might appear not to have capacity, with appropriate supports might be able to come up with a reasonable decision and they might be seen to have capacity. That is the case with intellectual disability, I think. That is a situation in which you need to ensure when you are assessing capacity for that group that you provide them with every possible opportunity to show that they have got capacity. For example, they may have a family member who can explain stuff for them and that may really help to understand and be able to assist. Again, is there a line in the sand with someone with intellectual disability? It is really easy when someone has an IQ of 20 or 30, because they have no capacity whatsoever. When someone has an IQ of 100,

if they are otherwise well, they have capacity. When someone's IQ starts to get into that grey zone, it then becomes an assessment of whether they can understand this process, with all the supports possible. Can you draw the line and say, "Okay, their IQ is 60, therefore they lack capacity"? There are things other than IQ that can inform capacity as well. Individuals with intellectual impairment are often defined by their IQ and are often defined by a couple of other functional measures. We would still need to do a proper capacity assessment for those individuals to see whether they could make that decision. As I said, at either end it is often very easy, but in those grey areas, you need the expert assessment. I do not know whether I have answered that question.

Mr R.R. WHITBY: You have.

Hon NICK GOIRAN: Dr Gibson, just going back to the last session from 14 December last year, you made the following comment —

Can I just say that, like the college of psychiatrists, I do not support physician-assisted suicide, but that is a different kettle of fish to voluntary-assisted dying.

In the various hearings that we have had throughout this inquiry, language and definition of terms have been quite an issue and from time to time people have been talking about things, with the questioner and the answerer actually talking about something completely different. Could you just indicate what that means, that you "do not support physician-assisted suicide, but that is a different kettle of fish to voluntary-assisted dying".

Dr GIBSON: When a doctor is standing there and actively injecting someone to end their life, knowing full well that what they are doing is the primary cause, is physician-assisted suicide. When an individual is provided with the information that allows them to voluntarily end their life, but when the physician is not actually involved in the direct ending of life, they are different. People will philosophically argue that they are the same and some people will philosophically argue that they are different. My opinion is that they are different entities and that I could not support a situation in which a physician was actively and physically and immediately ending someone's life.

Hon NICK GOIRAN: I am not going to debate that with you, least of all because I agree. But on the other issue, where the physician is not involved and yet the patient is enabled to suicide, what are the risks associated with that?

[1.40 pm]

Dr GIBSON: The issue is, of course, whether the person is provided with the appropriate information to ensure that the risks are low and that they are fully aware of the risks of what can happen if the method is not delivered properly. It is a bit like consenting—have you really provided enough information for the person to be able to proceed with the —

Hon NICK GOIRAN: Informed consent.

Dr GIBSON: Informed consent, yes.

Hon COLIN HOLT: Just to pursue that a little bit further, I understand the distinction you are making too. It is involvement in the delivery specifically with that patient to assist them. Potentially, if voluntary assisted dying is introduced, a person who has mental capacity has made the decision and it has all been approved in that way, but there is a physical incapacity to apply it. The doctor may have prescribed the right medication, but under your definition the doctor would not be there assisting the patient to take that medication. Any suggestions to overcome that dilemma?

Dr GIBSON: Again, it is a philosophical dilemma. People will argue whether they are in fact the same thing or not. The issue is that from the Hippocratic oath perspective, it becomes very difficult for a doctor to give the lethal dose, so to speak. We have vets doing that. You can argue that vets do that. I guess the issue is are there other processes or facilities within the community or within society

that will assist the person other than the medical practitioner? These are some of the logistics, again, which I have not particularly turned my mind to, because it gets down to the process and it gets down also to the philosophical debate of who can do what. I guess we could be guided by other legislation on that.

Hon NICK GOIRAN: Going back to the transcript of our previous hearing with you, my last question is: which mental disorders are terminal?

Dr GIBSON: I think I said last time that mental illness is not generally a terminal illness.

Hon NICK GOIRAN: You did.

Dr GIBSON: The difficulty we have is that the diagnostic criteria, such as DSM-5 or ICD-10, which are the two most widely used categorisation systems, include a mixture of those physical illnesses that could be terminal—for example, Alzheimer’s disease—and things like depression, which are not per se terminal. Obviously, suicide is a confounder in this mix as well because you could argue that some people have a higher risk of suiciding and, therefore, is that not terminal? I guess I am talking about the illness itself leading to the death of the person rather than the person taking their own life per se as a result of the illness. If you look at some physical illnesses like some dementias, they will lead to death, because that is the course of the illness, and they are defined as mental illnesses within the categorisation system. That is the difficulty with our current categorisation system. When you are categorising someone who has pneumonia of the lung, it is pretty easy. You have an infection in the lung, there it is, you give that treatment and they get better. It is no more complicated than that. But in mental illness, the categorisation systems are a work in progress, I guess you could say.

Hon NICK GOIRAN: I respect what you are saying—that it is a work in progress with the categorisation system. If legislation is moved and it is passed and a scheme of assisted dying is brought into place, the assessment will still need to be done on the current categorisation. On the current categorisation, are there any mental disorders that are terminal?

Dr GIBSON: Yes, there are—as in some of the dementias.

Hon NICK GOIRAN: Is it something about which you would be able to provide us with a list, either today or on another occasion?

Dr GIBSON: I certainly could.

Hon NICK GOIRAN: I should hasten to add that when I say on another occasion—just in writing. I am certainly not suggesting you come back a third time.

Dr GIBSON: I am happy to. The difficulty, of course, is that you have to be careful about using that as a “Yes, they are in” or “No, they are out”, because each will pose its own complications when you get into the grey zones with each. What I would say again, as I said earlier, is that people can have mental illness but still have the capacity to make decisions. It is not just about the illness per se. The capacity and the mental illness stuff is overlapping.

Hon NICK GOIRAN: I think your position is that if they have a mental illness, that should not be the reason that they access the scheme.

Dr GIBSON: Yes.

Mr R.R. WHITBY: Or are denied access.

Dr GIBSON: Yes.

Hon NICK GOIRAN: I want to be clear as to what are those types of mental illnesses which are terminal.

Dr GIBSON: Which are going to lead to death in somebody.

Hon NICK GOIRAN: That will obviously then be a factor that the lawmakers will have to take into account to decide who might and who might not be able to access the scheme.

Dr GIBSON: It is tricky, because it is also about prognosis. We know that prognosis is flawed. A cancer specialist might say that you have six months and you might last two years. It is the same with things like dementias. A specialist might say you have two to five years to live with this dementia, and someone might live for 10 years. So, there is also that issue of prognosis, I think, which lawmakers have to consider as part of the process.

Hon NICK GOIRAN: You will have no argument from me.

Hon ROBIN CHAPPLE: Mine comes down to fairly practical questions. Assuming that I have capacity—I am sure some of my colleagues might doubt that—and I come to you for an assessment, how long is that assessment going to take?

Dr GIBSON: It just depends.

Hon ROBIN CHAPPLE: I am very difficult!

Dr GIBSON: It just depends, of course. If there is a lot of third-party information that is just there ready to go and the person, as noted, is really clear and there is absolutely no sign, it might take less than an hour to make that assessment. If you have all the information, it will take less than an hour.

Hon ROBIN CHAPPLE: In my case, there is a lingering doubt.

Dr GIBSON: Where it is grey—where it is lingering—there are two things you might need to do. You might need to get further information, which might mean going away and investigating further from different third parties in different settings, or you might want to see the person again in a different setting. Let us say, for example, it is first up in the morning and they are bright and you might think they are doing really well. People with dementia have things called sunset syndrome, where cognitive impairment starts to get worse in the evenings. So you might then choose a particular time of the day. If you are suspecting a certain thing—for example, dementia—you might want to see the person again at five o'clock in the evening on another day. You may need another assessment. You may need more information. The nature of how long that takes depends on that individual person.

Hon ROBIN CHAPPLE: Ranging from a couple of hours to two or three weeks?

Dr GIBSON: Possibly. I would think it is unlikely that you would need two or three weeks. Within one to two weeks you should really be able to get that information that you need from the person. But there will always be outlying cases where it is difficult to get information, such as the person cannot come in at a certain time. There are logistic issues that might happen.

If everything goes to plan, it might only be two sessions. Very rarely, I think, you would need three sessions. For most people, it would be one session. Some might require two sessions with further information. But again, there are different variables that come into play.

[1.50 pm]

Hon ROBIN CHAPPLE: Secondly, should my GP refer me to a psychologist because he doubts I have capacity as well, how long would I have to wait to see a psychologist?

Dr GIBSON: These are the logistics issues, which I think the college of psychiatrists has raised. There are nearly 350 psychiatrists in WA. There is quite a large number. The private waiting lists are quite variable. Some people can be seen very quickly—within days. Other people have longer waitlists. So, that is a logistics issue, I think, regarding access. I have a slightly different view than the college of psychiatrists. I think there are enough psychiatrists to do what will probably be, as we have seen in other jurisdictions, a reasonably low number of requests. So, there may be processes that can be

put in place to ensure that these requests are done in a timely way given the numbers of psychiatrists we have for that particular purpose.

Hon ROBIN CHAPPLE: That would almost have to be some legislative provision, surely, because I certainly cannot just suddenly roll up on your doorstep or be referred to you on the doorstep.

Dr GIBSON: I guess it is whether it becomes a market process, whether some psychiatrists make themselves available for that particular process. As we know, when new treatments or new issues come up, you get individuals who then become interested in those particular areas. So it may be that there are a small number of people who are interested in doing that and for the purposes of their practice make themselves more available. So there may be some market forces that come into play there. I think it is hard to legislate that kind of stuff.

The CHAIR: We will take a final question from Hon Colin Holt.

Hon COLIN HOLT: Of the 350 psychiatrists, how many are in regional WA?

Dr GIBSON: That is a good question. I would have to go and add them up. The majority in regional WA are in the public system, so there are very few purely in private practices. There is a small number.

Hon COLIN HOLT: Could you do the capacity consultation via telehealth or is it a bit too complicated for that?

Dr GIBSON: I think an initial assessment could be done by telehealth if the line is working well, but you may end up needing to see the person face to face. Again, if it is a situation as was described where it is so obvious the person has capacity and the information is there, telehealth may be sufficient, but in those situations where there is a degree of doubt you may then need to have a further assessment. So, I would not rule out telehealth as an option, but it does not represent an absolute perfect face-to-face situation.

Hon COLIN HOLT: We have also heard evidence that most people prefer to die in their own home, which will present challenges for any consultation, I would have thought, around the regions as well as in Perth or anywhere else.

Dr GIBSON: Absolutely, logistic issues will come into play there, and we can think of all the logistic issues that will come into play, but if there was legislation, we would find more logistic issues that would come into play.

The CHAIR: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. The committee will write to you with questions taken on notice during the hearing. We really appreciate you coming back to us, Dr Gibson. Thank you very much.

Hearing concluded at 1.54 pm
