

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, 13 December 2017**

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 1.40 pm

DR KEIRON BRADLEY

Palliative Care, Clinical Lead, WA Cancer and Palliative Care Network, examined:

Ms AMANDA JANE BOLLETER

Program Manager, Palliative Care, Department of Health, examined:

MR LUKE HAYS

Acting Manager, Purchasing and Contracting, Department of Health, examined:

MRS MARIE BERNADETTE BAXTER

Executive Director, Nursing and Midwifery, WA Country Health Service, examined:

MRS MARION SLATTERY

Director, Nursing and Midwifery, South West, examined:

PROFESSOR GARY GEELHOED

Chief Medical Officer, Department of Health, examined:

The CHAIR: On behalf of the committee, I thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. I will not introduce the committee again. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in WA and highlight any gaps that may 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 apply to anything that you may 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. For the purposes of Hansard, just make sure you speak clearly so they can record the proceedings. Do you have any questions about your attendance here today?

The WITNESSES: No.

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

Prof. GEELHOED: Yes, I would. As you know, I was sitting here during the earlier session. I see it is termed end-of-life, but I am sure that later this afternoon you will probably get around to being a bit broader than that, but most of it was around palliative care, which is so important. Amanda pointed out that there is palliative care and then the end of life. In my role as the CMO for the last five years, one of my particular interests is to try to effect some sort of change in that area, the reason being that I think a lot of people, either professional or otherwise, are probably increasingly aware of cases where family, patients, parents, or whatever, will go into the medical system and so on, and at the end of that people say maybe that could have gone a bit differently, maybe we tried a bit too hard, et cetera, et cetera. I think there are a number of reasons for that. Obviously it is an ageing population and so on. There was a time when the area between life and death was pretty black and white, but now we can maintain people in that grey area, if you like, for a long, long time. There are so many things we can treat people for and so on, so the question becomes how do you use that in the most effective way. Certainly, I had some cases during my career, and I am trained

as a paediatrician, so that is why I became really involved with Amanda's group, and so I am looking at that.

How do we change those attitudes, because it is too easy sometimes, when someone comes into hospital, young doctors will just see the medical problem in front of themselves and start working on that medical problem rather than taking a broader view and stepping back and saying, "What is best for this particular patient in this context?" We know we spend a huge amount of the health budget in the last year of life, and if that actually meant that people could live longer and with an enhanced quality of life, that is money well spent, we think, but in many cases we know that that is not the case. In some ways, if we can do this better, it looks like it is a win-win-win situation for everyone in the sense that it is better for patients and I think for families, and probably better use of our resources.

By chance, to indulge a small anecdote, my dad is 97 and lives in Queensland. I visited there recently. He was found to have this cancer on his shin, and I thought we would probably leave that alone. If you asked, "Would you be surprised if this person died within the next year?", I hope he does not, but I would not be surprised if he did. My sister was on the phone saying that she had seen the plastic surgeon, and he wants to do a flap, and then they want to keep him in bed for five days, et cetera, et cetera. We have reversed that decision, but the point was that almost certainly he will die with that, not of that. That is just a small anecdote to show that we need to be much more looking at the patient holistically. I think we will hear more later in the afternoon about what we are doing in that area.

The CHAIR: One of the things we wanted to speak to you specifically about was consent and medical treatment. By way of background, could you explain the right of autonomy or self-determination in the context of medical treatment?

Prof. GEELHOED: It is really just respect for fellow human beings. If someone is competent and can make up their own mind about these things, then we will respect their decision. We give advice and take that decision. It gets complicated if the competency is questioned, or if it is a minor, or if there are other problems, but by and large it is very clear. It is also in keeping with the changing philosophy in medicine generally over the years, where it tended to be more autocratic, and the doctor just said what was going to be happening. Now we much more see it as a partnership where we work with people and suggest things, and they will take the advice or not take the advice. I think it is pretty well understood, and it is certainly taught in all our medical schools, and well-known throughout the hospital.

The CHAIR: Other than emergencies, is it correct to say that, in the absence of a person's consent to medical treatment, a health professional administering medical treatment might be liable under civil and criminal law for assault?

Prof. GEELHOED: As I say now, that is a standard thing. People say that if you do this against people's will, you are assaulting them, basically. With that caveat, obviously, about emergencies, that can get confusing, and sometimes when people turn up in emergency departments you need to then be able to make a decision, and sometimes you have to err on the side of treating. But again, this gets back to what we were saying before—a much better system where, hopefully, we do not get people turning up to emergency departments inappropriately, where those decisions are then forced on doctors who do not have the right information.

The CHAIR: Is it correct to say that although individuals have the right to refuse medical treatment, there is no right to require a health professional to administer a medical treatment?

Prof. GEELHOED: Again, obviously, if it is an emergency you would be expected to do your best, and that has been tested in the courts, too, recently, but generally speaking that is right. In the context of this meeting here today, people asking for treatment that they feel may help them, when the evidence is very clear that it is futile, again there is no compulsion for the doctor to treat that patient.

Hon Dr SALLY TALBOT: Can you give us the reference to the testing in court of the principle? You might have to take it on notice.

Prof. GEELHOED: Yes I can—it has gone out of my mind now, but I will get it to you.

The CHAIR: You have before you our questions on the refusal of medical care. I would appreciate it if you could address us on this topic.

Prof. GEELHOED: Refusal of medical care, is like what I said about consent, really—it is just that. If someone is competent and of sound mind and so on, and for whatever reason they decide they will not take the advice of the health professions, then they have every right, and that is respected. It can be for all sorts of reasons. It might be around end of life and a different interpretation of what that means, but it also may be people with religious beliefs and things like that. There are some high-profile cases there. Again, generally, if they are making a decision about themselves, then that is respected.

Hon ROBIN CHAPPLE: You said, “if they are of sound mind”. Who makes that deliberation?

Prof. GEELHOED: That is difficult, and at times that really has to be tested, depending on the decisions being made and what the consequences of the decision are. Clearly the thing here is if there is mental capacity—if a person clearly is psychotic and out of touch with reality or something, then clearly it would be wrong to take that person’s advice on that. It may mean getting a psychiatric opinion or further opinion. Does that answer your question?

Hon ROBIN CHAPPLE: Yes, thank you.

[1.50 pm]

The CHAIR: Are the arrangements relating to refusal of medical treatment well understood and respected by health professionals consistently in WA, in your opinion?

Prof. GEELHOED: Again, it would have to be my opinion, but I guess I would have to say my opinion is informed by the different committees I sit on and the things that come across my desk and so on. We sit on the coronial review committee where you look at a lot of contentious cases there. The peak incident review committee, again, looks at all the—and many things come to me. I guess what I am saying is no, it is not an issue that has come to me as Chief Medical Officer.

The CHAIR: An understanding of consent and withdrawing consent —

Prof. GEELHOED: Yes, I think there is an understanding. I guess what I am saying is there are no issues coming up that have been referred to me because there is a lack of understanding, so I am assuming there is, but, you know.

The CHAIR: On what basis is the refusal of medical treatment distinguished from conduct which might otherwise be a suicide attempt?

Prof. GEELHOED: Look, this would be rare, I would think, and difficult, but the two things there—I mean, usually they would distinguish themselves. One is about refusing treatment to go ahead with something like that, as opposed to someone who was doing something active, so suicide in terms of taking something to actually—now it gets confusing. I am sure you are going to bring up about refusing food and that sort of thing, but usually it is not a practical issue—very rarely.

The CHAIR: Does permitting the refusal of medical treatment compromise efforts to reduce suicide generally in the community?

Prof. GEELHOED: No. That would be my opinion. I think the community generally would be reassured that the health professions respect people's wishes in this. I think it would be seen as a very positive thing and I think the two are quite separate. I do not think that there is an overlap there or confusion in the public's mind.

The CHAIR: Is the relationship between health professionals and patients compromised by permitting the refusal of medical treatment?

Prof. GEELHOED: Again, I would probably give the same answer and say no. If anything, I think it reassures people that they have control over the decisions and the treatments they get.

The CHAIR: Does the Department of Health monitor and report incidents where medical treatment is refused?

Prof. GEELHOED: Look, no, they do not, generally speaking. I mean, some of these things, although I cannot think of any off the top of my head, may come up in the incidents being reported for different reasons. One of the reasons why a lot of this is, if you like, lacking and some of the questions that you asked in the earlier session is, I guess—we may need look at this, because end of life is, if you like, becoming quite—well, there is a focus on it, shall we say. But this is all really thought of as business as usual; it is just the way we treat people. So, there was not any thought that there was a need to report all these things because it was just people doing their job, really. But going forward, it may well be that this might be something we could consider.

The CHAIR: Does the department evaluate the medical management of incidents where medical treatment is refused?

Prof. GEELHOED: No, for the same reason, unless there is something more to it. Other than the fact that when you say the department—Amanda made the point that since July last year there is an assistant manager role and so on, but all hospitals have to have, usually, a mortality and morbidity committee or called something along those lines, where they do review all these deaths. If that is an issue around that, it would be reviewed in that setting.

The CHAIR: Is statistical data on incidents where medical treatment was refused kept by the department?

Prof. GEELHOED: No, for the reasons I said before.

The CHAIR: Are there any concerns that vulnerable people are being influenced or coerced into refusing medical treatment?

Prof. GEELHOED: Not on my part. We all know what human beings can be like, but, again, in my five years in the job, there has never been anything raised along those lines in any of the incidents and that. So, all I can say is I do not think so. That would be my opinion.

The CHAIR: Are there any concerns that substitute decision-makers for vulnerable people are being influenced to refuse medical treatment or are exploiting their positions in their own interests?

Prof. GEELHOED: It is really the same answer. I am not aware of any concerns that have come up. I cannot say that that has not happened, but no.

The CHAIR: Where patients do refuse medical treatment, how does the department ensure patient safety in these cases?

Prof. GEELHOED: I guess by adhering to all the policies and practices and review, and, generally speaking, people are pretty sensible. If something comes up that is out of the ordinary, they will get

second opinions themselves. They will actually refer to more senior people, and in some cases, even referring for ethical consideration and so on. But, again, I would say it is sort of business as usual. These things are all reviewed at some stage; if someone dies, it gets reviewed. If there are any issues along those lines, they would take it up there.

The CHAIR: What does the Department of Health do to ensure that the laws on the refusal of medical treatment are well understood and respected consistently by health professionals?

Prof. GEELHOED: I guess our medical schools teach this and I am sure it is part of nursing training as well.

Mrs SLATTERY: Yes.

Prof. GEELHOED: So right from the start those broad principles are introduced. A lot of the programs that we have—the e-learning packages and so on around advance care directives and all that sort of stuff—all sort of mention this as well. There are many. I can list them, if you like, but it is something well appreciated, well known and brought up in different forums.

Hon NICK GOIRAN: Professor, this touches on the topic that was discussed in the earlier session. Are you able to inform the committee where in our state palliated starvation and terminal sedation is practised?

Prof. GEELHOED: I am the Chief Medical Officer. I ran the emergency department at PMH for 22 years, so that is my experience. At times there, I had to deal with death and dying and children with chronic conditions. That is my experience, but there are much more experienced people. I am happy to answer it, but I just make that caveat, if you like. My feeling would be that most of these things are standard treatment. We are caring professions. We are trying to do the best for the patient. We have a lot of protocols in medicine, but the art of medicine is very, very real and it is taking each individual case, balancing the needs of the patients, and to some extent the families et cetera, and so into the mix goes all those things about how much medication you give and whether you are giving nourishment or not. As was explained before very well, and I have seen this in two cases recently—and when I say “cases”, a good friend and my sister-in-law went through palliative care—the question of nutrition and food and all that becomes a bit academic in a way. It is sort of like if you are talking about taking away or giving it, often it just sorts itself out. These people literally cannot take it because they have so much nausea that cannot be controlled or something. The question of someone literally deciding not to take these things in sound mind and reasonably healthy is, I think, extremely rare, as was said. It is a mix of all those things at the end—trying to balance medication to help the symptoms, but not cloud consciousness if at all possible. It is a woolly answer, but what I am saying is I think it is a case-by-case basis.

Hon NICK GOIRAN: It is a little woolly, but that is okay. We will unpick it. I will just park the palliated starvation to one side on the basis that you are saying it is more academic; it is quite common that people will lose appetite and so forth or they cannot take hydration.

Prof. GEELHOED: That is my understanding, yes, or it is just futile in the sense that if they lost consciousness, there is no point giving intravenous fluids forever to try to keep them alive for a few more days. It is that sort of practical consideration.

Hon NICK GOIRAN: Terminal sedation is something quite different. In what setting does terminal sedation take place in Western Australia? Does it take place always in a hospital or can it take place in another setting other than a hospital?

Prof. GEELHOED: I think it could, but I would throw that to my colleague here. I am sure that is part of the palliative care.

Dr BRADLEY: It can take place in a hospital setting, it can take place in a hospice setting, but it can also take place in a community setting with the support of community services.

Hon NICK GOIRAN: Hospital and hospice are very self-explanatory. Can you explain community setting?

Dr BRADLEY: In patients' homes or within residential aged-care facilities.

Hon NICK GOIRAN: Terminal sedation could take place or does take place in Western Australia in people's homes?

Dr BRADLEY: Yes.

Hon NICK GOIRAN: Who would oversee it? Who would administer that?

Dr BRADLEY: It would be, generally, in that circumstance—I cannot say for sure, but my clinical experience would be—overseen by a specialist palliative care service. So it would be Silver Chain or the metropolitan ambulatory palliative care service, if it is in residential aged-care facilities, but in rural areas, then obviously it would be under the kind of guidance of the palliative care team.

[2.00 pm]

Mrs BAXTER: It would be the regional palliative care team and in consultation and partnership with the general practitioner.

Hon NICK GOIRAN: So if the committee wants to know more about this issue of terminal sedation, will the people to speak to be the hospitals, the hospices and the community service providers?

Dr BRADLEY: From an individual point of view, yes. If there are any specific questions, I am more than happy to try to answer them.

Hon NICK GOIRAN: One other question was in respect to statistical data on incidents where medical treatment was refused, and the answer was that the department does not keep statistics on that.

Prof. GEELHOED: No.

Hon NICK GOIRAN: Does the department receive requests from time to time for people to undertake research and therefore then authorise researchers to collect data? If that is the case, has this topic of refusal of medical treatment been a research request that you are aware of?

Prof. GEELHOED: Not that I am aware of. I could not say categorically, but I am not aware of it. I do not know if anyone else is. No.

Mr J.E. McGRATH: Where someone is in palliative care but they also have a GP, and the GP has been with them for 20 years or something, so he is basically the person charged with the responsibility of looking after his or her patient, what is the role of the palliative care provider and the GP? How often is the GP called on, or how much oversight does he have?

Prof. GEELHOED: I would say it is a case-by-case thing, in a way. Certainly in the country and places like Bunbury, some of the GPs there are very involved in palliative care and actually provide that service themselves, that I know of. But I would think, like in any broader medicine, the GP is often seen as the primary person and the palliative care person would be there to help as much as anything, to be part of it, to support the GP. It would be a partnership; that is the way I would see it.

Mrs SLATTERY: That is correct, yes.

Mr J.E. McGRATH: Is the palliative care provider able to inject and do things like that or is that only the GP? When you are talking about people being close to death, when they need some treatment

to just ease the way out, would that be through tablet form, or through injections; and, if so, who would do the injecting?

Dr BRADLEY: Generally because patients are close to the end of life, they are not able to swallow tablets because that ability goes with the ability to eat and drink as well. So normally it would be by injection. Those injections can be done by any of the healthcare professions that are looking after that person, whether it be a GP, Silver Chain or nursing staff that are looking after that person, so long as they feel they are the appropriate person to be doing it. That generally, from a sedation point of view, is often done as an ongoing situation rather than just a once-off injection, because obviously a once-off injection would wear off. It would not necessarily be appropriate for someone's management of their suffering at the end of life if the injection worked for four hours and then wore off and they would have to wait for someone else to come back and do another injection. So we will often use a 24-hour means of giving the medication so that they get that ongoing —

The CHAIR: Like a pump?

Dr BRADLEY: Exactly like a pump, yes.

Hon Dr SALLY TALBOT: My question is on the same subject. Could you go a bit further in terms of the explanation about who can administer the procedure that we are calling “terminal sedation”? Clearly, a doctor can do it and a nurse practitioner can do it. But are you saying that you would not have to be a registered nurse to administer the injection?

Mrs SLATTERY: It is the registered nurses that attend the home.

Hon Dr SALLY TALBOT: So you would have to be a registered nurse or a doctor?

Mrs SLATTERY: Yes.

Hon Dr SALLY TALBOT: So it is not care providers in general? At one stage I think you —

Dr BRADLEY: No, sorry. If I said that, I did not mean general care providers. I meant healthcare providers, as in doctors or nurses.

Mrs BAXTER: It is registered health professionals, which is why we tend to look to the 24-hour pump. Assistance to the family does not necessarily need to be by a registered nurse. An enrolled nurse can support them in those circumstances and not have to be concerned about their inability to deliver schedule 8 medications—opioid medications.

Hon COLIN HOLT: Could I just follow that up a bit more? The patient is being treated for, say, cancer. Not much more can be done and they are sent home for comfort and palliative care. A system is set up where a clinician sets up the injection in the pump, and the clinician goes home, leaving the patient with a carer—a family member, probably. Can they use the pump in that situation without a clinician around?

Mrs BAXTER: It is locked.

slat: They are locked.

Hon COLIN HOLT: It is locked?

Mrs BAXTER: Yes. It is a continuous delivery of a specific amount of medication over a 24-hour period.

Hon Dr SALLY TALBOT: You cannot change the dose?

Hon COLIN HOLT: You cannot change the dose?

Mrs BAXTER: No.

Mrs SLATTERY: No.

The CHAIR: My next question is for the professor around legal issues for health professionals. Studies in other states show that among doctors practising in the end-of-life field, there were significant knowledge gaps about the law in this area. Has any equivalent study been conducted in WA that you are aware of?

Prof. GEELHOED: No, not that I am aware of.

Hon NICK GOIRAN: Are you aware of the studies in the other states that were referred to by the chair?

Prof. GEELHOED: Not specifically, no.

Hon NICK GOIRAN: I have to say nor am I.

Prof. GEELHOED: Good.

The CHAIR: We can provide further information on that.

Prof. GEELHOED: Thank you.

The CHAIR: What does the department do to assist health professionals become fully informed of the legal complexities in this area?

Prof. GEELHOED: I sort of mentioned that before—there are various education programs. Some of the things I have here are undergraduate education; it is certainly mentioned there. There is staff orientation for some of them. There are various policies. We have an advance care planning eLearning resource that people will access. We have a draft policy that we are circulating at the moment that has been widely circulated already for comment. It is all of those things, trying to raise consciousness. As you can imagine, there are so many pressing issues in medicine that trying to cut through anything is difficult. That is why in the whole end-of-life steering committee, the work we have done in the last few years was to try and change the whole culture and the system so that people are aware of this and, in a broader sense, will approach these things a little differently to perhaps five or 10 years ago.

Mr J.E. McGRATH: Professor, in my electorate of South Perth, we have a lot of older people. I have had discussions with a couple of well-regarded GPs and they have both expressed concern to me that we probably need to be able to do a bit more for those people who are suffering. I was surprised to hear them say that. Are you finding that as Chief Medical Officer you are hearing concerns from GPs around the state who are saying that maybe we could do it better or that the community is asking for more?

Prof. GEELHOED: You have heard a lot of the detail about palliative care, and we can certainly do a lot more there, but the budget is only so big et cetera, so there is that to it. We are sort of getting into tiger country here, too. I think it is probably fair to say that the medical profession has divided views on how much should be done in end-of-life situations, just as in the general public.

The CHAIR: I want to follow up on a comment that you made previously around the committee that is looking into end-of-life care and that culture change. Can you give us an outline of what you think that culture was and what needs to change?

Prof. GEELHOED: I sort of said before a little bit about why I think this has happened. For instance, when I started as a young doctor, intensive care units were essentially for reasonably young people who had a catastrophic illness or injury and they went in there and they recovered with that intensive care and out they went again. You generally could not get into an intensive care unit if you were over 70 years of age. Now, I was 23—I thought that was reasonable! But now, if you look at our intensive care units, many of them have people who are very, very old. That is not to say it is inappropriate, but some of the people who are there essentially are probably not going to leave

hospital. So there has been a real change and it has crept up on us to some extent. As I say, for a lot of junior doctors, when someone comes into hospital and they have medical problems, they just go into automatic mode and start ordering tests, giving the treatment, doing all that stuff, and you go down that road. You may know patients—others would probably be better to speak about this than me—who have cancer and so on who are being treated and treated and treated when there is no clear evidence or discussion about what is the endpoint and what are we achieving.

[2.10 pm]

We are not alone in this. Many jurisdictions are doing this, over east and around the world. They can see this is a problem and we can do much, much better. The whole idea is, what we are trying to do is, we are mainly concentrating on what we can do in the hospitals so that when they turn up, if they have advance care directives, that is flagged and people straightaway know that a conversation has been had about what is going forward and so on. A plan will be put in place with different levels. It will be discussed with the person if they are competent, or the families and so on. So you have goals of care as to what you are trying to achieve with this admission as opposed to in the past it was a bit like going into automatic and a lot of things happened that perhaps did not need to be done. It may be in some situations where people literally come in and, perhaps with the right conversation and all the rest of it, it is all decided that they can actually go home rather than come in and have all sorts of things done. Does that answer your question?

The CHAIR: Yes, thank you. Back to the legal and health issues, are the protections, in your view, under the Criminal Code for health professionals in relation to treating patients at the end of their lives sufficient?

Prof. GEELHOED: I would say I think they are, just in the sense that again people are dying all the time in hospital and out of hospital. It has not been a problem; very occasionally there will be difficult cases come before the courts and we have had some in WA, but other than that I am not aware that there is a problem.

Hon NICK GOIRAN: I just want to look at the issue of misdiagnosis. From time to time a health practitioner might misdiagnose a patient. When that happens, is there a central place where those incidents are recorded other than, for instance, a claim made to the medical insurer?

Prof. GEELHOED: There is no simple answer to that. If the consequences of the diagnosis were catastrophic, almost certainly it would come to everyone's attention. It would be reported as an incident and so on, as opposed to someone gets admitted to hospital and a junior doctor sees them and thinks it is one thing and a senior doctor comes along and says, "No, it's not." You know, there is a whole range there. To answer the question of whether there is a definitive—misdiagnosis of a case with consequences would almost certainly come to our attention through the peak incident review committee and, sadly, maybe through the coroner. If the consequences were that severe, we would then get feedback from the coroner.

Hon NICK GOIRAN: So when you referred to it maybe being reported as an incident, does that mean getting reported to this peak incident review committee?

Prof. GEELHOED: Yes.

Hon NICK GOIRAN: That is the process. So who makes up this peak incident review committee?

Prof. GEELHOED: It is a broad representation from the department itself and then all the hospitals. There is legal representation and a broad range of emergency positions, ICU —

Hon NICK GOIRAN: Okay, and there is just one committee for Western Australia?

Prof. GEELHOED: That one, yes, but that is more or less feeding in from essentially similar committees in each of the hospitals who report these things and send them up to the Department of Health.

Hon NICK GOIRAN: Up to this peak committee?

Prof. GEELHOED: Yes.

Hon NICK GOIRAN: Okay.

Mrs BAXTER: Each area health service has an overarching incident review committee, which receives what we call the clinical incident management forms and makes the determination as to what level of severity the incident is and those, say on severity 1, would be referred immediately to the Department of Health system manager peak incident, and then severity 2s and 3s would undergo the assessment within a local area health service and make a determination as to which one of those should refer to the peak incident committee.

Hon NICK GOIRAN: So, some incidents might not make their way to the peak committee.

Prof. GEELHOED: That is right. By definition, we are looking at the ones that we feel are very serious but also might have system-wide implications, as opposed to ones that are relatively minor and can be managed within the hospital.

Hon NICK GOIRAN: My question started off with respect to misdiagnosis. Would this committee, either at the local level or the peak incident review committee, also deal with circumstances of what I am going to refer to as mistakes. Health practitioners are human beings; they are not robots, so they make mistakes from time to time. Misdiagnosis might be one type of mistake, but there might be another type of mistake which is they have actually diagnosed the patient correctly but they have—again, this is my word—mistreated them; they have not treated them correctly. Would that also be the type of incident that might go to this committee?

Prof. GEELHOED: Possibly, depending on the consequences, but there are other checks and balances there too, in terms of a departmental head will be monitoring all these things within their department and so on. We try to encourage a no-blame open sort of way of reporting in the hospitals and so on, so all staff are empowered to bring things up, because sometimes people are not even aware of it. It is really about safety and quality and trying to have that. Again, culture is so important, where people are open to feedback and people can report these things. Depending on the severity, though, they would get formally assessed; and, if it is negligent, if it is that level, then action will be taken by the medical board or the nursing equivalent if necessary.

Hon NICK GOIRAN: Last question on this point. Incidents of this nature in a hospital will make their way to the local committee or the peak committee, depending on the severity. Would incidents of this sort also make their way to the respective committees if the incident is hospice-related or, say for instance, at home, and the provider was something like Silver Chain?

Prof. GEELHOED: It would depend on the governance structure.

Mrs BAXTER: Definitely I will leave Silver Chain to speak on their own, but any of the health professionals employed by the WA Department of Health, by virtue of their contractual requirements, are duty bound to report any clinical incidents through the system, whether it be at home, in an aged-care facility, in a hospital or in any other setting in which they are employed to work.

Hon ROBIN CHAPPLE: Thank you. Obviously, there is a process here. Do you think you could provide us with some information—the criteria or the structure of how this process occurs? That would be, I think, useful.

Prof. GEELHOED: Yes.

The CHAIR: I am going to move to the doctrine of double effect. I understand that Dr Bradley is the best witness to address this area. I would appreciate it if you could address us on this topic, although your colleagues, of course, are welcome to comment. I note, too, that we have been given notice of some areas in relation to which you have received legal advice not to respond. For the purposes of the public record, the committee would ask that you indicate this in your address, in addition to the basis on which you have been advised not to respond. What is the doctrine of double effect, and how does it operate in WA?

Dr BRADLEY: The doctrine of double effect is a complex ethical principle. It is where an action that you take may have two foreseen effects. One is a good effect, which would be classified as the intended effect, and the second one is a harmful effect; it is not intended, but it is foreseen, and that is the differentiation. If we are looking at a formal definition of it, I have taken it from an ethics textbook by Beauchamp and Childress. They say that to be very specific, four conditions need to be met for the doctrine of double effect to be justified. The first one is about the nature of the act. The act must be good or at least be morally neutral, independent of the consequences. The second is what the agent's intention is. The agent's intention must only be for good, so that the intention is for the good consequence. The bad effect is obviously foreseen, tolerated and permitted, but is not intended. The third is the distinction between means and effects, so the bad effect must not be a means to the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect, and that is not the doctrine of double effect.

Proportionality, then, between the good effect and the bad is the fourth point, so that the good effect must outweigh the bad effect. That is the fourth criteria that needs to be met for the doctrine of double effect to be justified. Is that helpful?

[2.20 pm]

The CHAIR: Thank you. What is the physical process of dying associated with increasing doses of opiate or derivatives or other sedating or pain-relieving medications?

Dr BRADLEY: That one I have been advised not to answer from legal.

The CHAIR: Is the administration of increasing amounts of opiate or derivatives or other pain-relieving or sedating medications recorded as the cause of death on the death certificate?

Dr BRADLEY: So the cause of death recorded on any death certificate is what to the best knowledge of the doctor that they believe is responsible for their death.

Hon Dr SALLY TALBOT: May I just ask for a point of clarification through you, Madam Chair. If the answer to your question is that the witness has received legal advice not to respond—I think earlier you asked for the reason for that legal advice.

The CHAIR: Yes.

Hon Dr SALLY TALBOT: Would it be helpful, perhaps, if we asked witnesses to give us that information in relation to these questions as well?

The CHAIR: Yes, okay. Are you able to outline the reason under which your legal advisers advised you not to respond?

Dr BRADLEY: I have been told that that reason is covered by legal privilege.

The CHAIR: Right.

Hon Dr SALLY TALBOT: By legal privilege?

Hon NICK GOIRAN: Legal professional privilege.

Dr BRADLEY: Yes.

Hon NICK GOIRAN: So obviously the witness has received the legal advice and is not prepared to disclose and release the privilege. We have this all the time, do we not, when governments will not provide —

Hon Dr SALLY TALBOT: Yes. So we are clear that it is the witness whose legal rights are being protected by—sorry; it is not a trick question. I am only seeking clarity; I am not seeking to catch anybody out, I promise you.

Dr BRADLEY: Thank you.

Hon Dr SALLY TALBOT: I might come back and ask a couple of questions in the light of that when you finish.

The CHAIR: Okay. Is the administration of increasing amounts of opiate or derivatives or other pain-relieving or sedating medications recorded as the cause of death? I think we did that one.

Dr BRADLEY: Yes.

The CHAIR: Yes. Is it true that there is no clinical scientific evidence that morphine causes death if used with appropriate skill to treat symptoms, and in particular that its respiratory depressant effects have been shown to be minimal?

Dr BRADLEY: I personally do not have an exhaustive knowledge of the clinical scientific evidence surrounding morphine safety, but I have a very good working clinical knowledge on it. My belief is that there is good quality evidence to suggest that morphine is an extremely safe drug, when used with appropriate skill, to treat symptoms, and when it is titrated appropriately as well dose-wise. It is used, obviously, extensively throughout the world in a very diverse patient population, and my clinical experience from the respiratory depression point of view is, again, that there are very minimal risks or negligible risks when used safely and appropriately.

Hon NICK GOIRAN: Can we pursue this a little further, because it is a very interesting point. We often hear people say something along the lines of, “The doctor upped the morphine, and that’s what killed her or killed him.” Is that clinically possible?

Dr BRADLEY: It is clinically possible. If I was to go and give someone a very large dose of morphine, obviously that would kill them if they are not used to having morphine-based medicines. When we are talking about general care for someone who is at the end of their life, if you are using morphine appropriately to manage their symptoms, then the morphine is not what kills them; they are dying of the underlying problem.

The CHAIR: Is the consent of the patient or the person authorised to consent on their behalf required?

Dr BRADLEY: I am assuming that relates to morphine use?

The CHAIR: Yes.

Dr BRADLEY: So, consent is required for all treatments, including the use of morphine, other than an emergency situation, as per the Guardianship and Administration Act 1990. But, obviously, in an emergency situation you would use appropriate symptom management whilst awaiting decisions, so we would obviously not leave someone suffering with extreme pain whilst you are clarifying that consent.

Hon NICK GOIRAN: So consent is required, did you say, in all treatments? The part where you talked about consent is required in all treatments, I think you said.

Dr BRADLEY: Yes, except in an emergency situation.

Hon NICK GOIRAN: So consent would therefore then also be required with regard palliated starvation and terminal sedation—all treatments?

Dr BRADLEY: All treatments.

Hon ROBIN CHAPPLE: Yet, if I may, just on this point, you have —

Dr BRADLEY: But obviously from the point of view of all treatments, but removal of something is—obviously, palliative starvation is a patient's choice to remove something—to not take something. So it is not actually a treatment.

Hon NICK GOIRAN: Okay. That is an important distinction to make.

Dr BRADLEY: Absolutely. So managing the symptoms that they may get if they choose to stop eating and drinking, they would need to consent for, because obviously that would be provided by a healthcare professional. But the actual stopping eating and drinking in a palliative starvation situation does not need consent.

Hon NICK GOIRAN: Yes. That is why in the Rossiter case with Brightwater that the hydration, as I understand it, and the peg—the tube—was considered to be the medical treatment, and hence there needed to be a decision made as to whether the patient can consent to have that medical treatment removed. Are you saying that is different to placing a cup of coffee in front of somebody and it is up to them whether they want to take it or not?

Dr BRADLEY: Absolutely. It is artificial nutrition and hydration versus non-artificial.

Hon Dr SALLY TALBOT: Which is the treatment, not the withdrawal of the hydration. The withdrawal of the hydration is not a treatment.

Dr BRADLEY: Yes.

Hon Dr SALLY TALBOT: I think that is what —

Dr BRADLEY: But it also depends on how the hydration is provided, because if we are providing hydration through a drip or a nasogastric tube or a peg tube, that is artificial hydration, which is actually a treatment because it is not a natural process.

The CHAIR: Yes.

Hon NICK GOIRAN: It is the artificial nature of it that converts it to treatment, thereby requiring consent.

Dr BRADLEY: Yes.

Hon Dr SALLY TALBOT: I think your original question was: is consent required by the treating medical staff for —

Hon NICK GOIRAN: No, no, by the patient.

Hon Dr SALLY TALBOT: Yes, yes. Is consent required for the withdrawal of, or the refusal of, hydration or nutrition?

Hon NICK GOIRAN: Yes. It was about palliated starvation.

Hon Dr SALLY TALBOT: What the witness is saying is that that is not a treatment.

Dr BRADLEY: Yes.

Hon NICK GOIRAN: I think that is the evidence, that palliated starvation is not medical treatment.

Dr BRADLEY: No, that is right—someone choosing not to eat or drink, yes.

Hon NICK GOIRAN: Hence why the consent issues are different.

Hon Dr SALLY TALBOT: Yes.

Dr BRADLEY: Yes.

Hon ROBIN CHAPPLE: Just again going back on that point, I am trying to refresh my mind. Earlier on I asked you a question about when somebody was terminally ill, and you talked about the time lines. But we also talked about relatives and clinical professionals making decisions. Why is that different from this instance, where you require a patient's consent here and not in the previous time?

Dr BRADLEY: It would depend on if the patient is able to provide consent. That may be the —

Hon ROBIN CHAPPLE: So if the patient cannot provide consent, we actually turn to others to make that decision.

Dr BRADLEY: Yes—for treatment decisions, absolutely.

Prof. GEELHOED: Perhaps guided by, if they have got an advance care directive —

Dr BRADLEY: Absolutely.

Prof. GEELHOED: — and they are very clear about it—what they want to do is very clear.

Hon NICK GOIRAN: There is a hierarchy of decision-making.

Prof. GEELHOED: Yes.

Hon ROBIN CHAPPLE: If there is no advance care.

Dr BRADLEY: Yes.

Hon ROBIN CHAPPLE: If there is no advance care directive, what happens then?

Ms BOLLETER: We will come to this in our evidence later this afternoon under “Advance Care Planning”. We will provide you with a copy of the hierarchy of decision-makers, and more information about advance health directives and how they work in that context.

The CHAIR: Thank you.

Hon COLIN HOLT: You said earlier when you were talking about double effects and the four points that the good must outweigh the bad. I am going to make a statement and you can say if I am correct or not. So you apply morphine to relieve some pain, but the bad effect is that they actually die. Would that be right? Is that correct?

Dr BRADLEY: I think there is very good evidence now that morphine does not cause death when used appropriately, so therefore I do not think morphine is an appropriate —

Hon ROBIN CHAPPLE: Use another drug.

Dr BRADLEY: — example for the doctrine of double effect.

Hon COLIN HOLT: Okay. Let us say you use a drug for pain relief as the good part of the double effect, but it actually causes death. Is that accurate? Is that statement accurate?

Prof. GEELHOED: That is true.

Hon COLIN HOLT: So the good thing is pain relief; the bad thing is —

Prof. GEELHOED: The principle there being that it is a very complex area, you are trying to do the right thing by the patient, and it is not just longevity of life that is important; it is quality of life and trying to balance those two. So if in good faith someone is providing treatments that may hasten death a bit but provides more comfort, that is accepted by the profession, yes.

[2.30 pm]

Hon COLIN HOLT: I understand the difficulties. In that circumstance, how is the bad effect of death really outweighed by the good effect?

Prof. GEELHOED: The bad effect of death in that situation I think is irrelevant because it is going to happen anyway, whether it happens today, tomorrow or the next week. That is the point. In that sense, you are trading off quality of life and length of life. We are talking about people who are about to die. The fact they are dying is almost irrelevant.

Hon COLIN HOLT: So because they are going to die, the hastening of death through the double effect is not seen to outweigh the treatment of the good in terms of pain relief et cetera? You talked about weighing the good and the bad. Death is pretty bad, pretty terminal, although I take the point —

Prof. GEELHOED: In the situation where death is inevitable, if you are providing comfort and if you are relieving suffering, that is thought to be a reasonable trade-off. We are getting into the deep philosophical stuff here. If your intention is to relieve suffering, then it is accepted that if, inadvertently, it shortens life a little, that is acceptable.

Hon NICK GOIRAN: It revolves around the fact that it might cause the death of the person.

Prof. GEELHOED: Or might hasten.

Hon NICK GOIRAN: Yes, rather than guaranteeing.

Prof. GEELHOED: Absolutely.

Hon NICK GOIRAN: Presumably it would be a different thing if, as a medical practitioner, you are about to inject somebody with some pain medication, and you knew that by doing this it guaranteed the death of a person, double effect does not apply.

Prof. GEELHOED: Yes, that is a completely —

Hon NICK GOIRAN: We were not talking about a trade-off. The trade-off with regard to the bad is the possibility rather than the guarantee that death will ensue.

Dr BRADLEY: Obviously, every individual patient would need to make that call as to what to them was most important—would it be controlling their symptoms or would it be the risk that their life might be shortened by a small period of time? That is an individual decision as well.

Hon ROBIN CHAPPLE: I want to follow up on this and I go to you, Professor Geelhoed. We come back to this issue of somebody is going to die, and we have this time line issue, and I think we talked about this previously. So when it comes to the dose of double effect—which is there, as we have identified, not to do the bad thing but to do the good thing—what is the time line? We have a patient who is very, very ill, and without medication to relieve their suffering—balanced medication to relieve their suffering—they might carry on, as my mother did, for several months. At what stage do you medicate people to relieve their suffering, which may or may not include the dose of double effect, in a time-line scenario? If you medicate somebody to the point at which they are relieved of their suffering, but the unintended consequence of death occurs, and you are saying that that occurs while somebody is terminal, what is that period of time?

Prof. GEELHOED: I will let Dr Bradley answer this, but I just make this comment. As I said before, and this is really quite an important thing, when a doctor answers the question, “Would you be surprised if the patient dies in the next year?”, that is quite a powerful thing. In the same way, what we are talking about here is you would not be surprised if this patient dies in the next day or the next couple of days. We are not talking about next month.

Dr BRADLEY: I agree. We are talking about a short period of time. I go back to the fact that I do not think the medications we use, when they are used appropriately, do actually hasten death. But I

think the bottom line is that we need to be using them appropriately to manage that person's symptoms. Even if there is a small risk that it brings it forward by a small period of time, we know that person is close to death, so control of their symptoms and their suffering is vitally important. Not everybody, but the majority of patients that I look after who are at the very end of their life would very much accept a risk that their life might be shortened by a short period of time, be it a day or two or three, for the fact that I would get their symptoms better controlled.

The CHAIR: What does the Department of Health do to ensure that the doctrine of double effect, to the extent it is reflected in the provisions of the Criminal Code, is well understood and respected consistently in WA?

Dr BRADLEY: It is not a role of the Department of Health to provide direct training and education to clinicians on this topic, as it is the responsibility of the employing organisation—the health service providers—as part of their orientation and ongoing training. It is the responsibility of health professionals as part of their registration to comply with the state and federal laws, but through the contract with the Department of Health to deliver palliative care education, the PaSCE curriculum does cover this topic in its foundation modules and in extension sessions. It is also included in all advance care planning education provided. The target audience for this training would be medical, including GPs, nurses, allied health and care facility managers.

Hon NICK GOIRAN: Earlier this morning, evidence was given that the committee that you chair had provided some feedback to indicate that part of the concern about whether palliative care is well understood in our community revolves around confusion on definitions. Is there a view, either from yourself or from the committee, that there is confusion in the community about this doctrine of double effect?

Dr BRADLEY: We would have to go back through and double-check if that has ever been raised as a concern. It was not raised as an issue at the recent meeting when we mentioned —

Ms BOLLETER: It has not been raised in my memory.

Hon NICK GOIRAN: Do any of the witnesses have any concerns that the community does not understand the doctrine of double effect?

Ms BOLLETER: I do not have evidence to hand which shows what is the community's level of understanding, and I think it is important not to speculate about what the community's understanding might be.

Hon NICK GOIRAN: Do we have any evidence about whether health practitioners have a good understanding of the doctrine of double effect?

Prof. GEELHOED: Again, it is opinion, I suppose. Speaking to many, many doctors, most doctors—I am sure all doctors—say they will come across death of patients at some stage, so it is something that is crucial to all of them. Every doctor I have ever raised it with, or talked about it with, knows what you are talking about, just because it is such an important topic, I guess.

Hon NICK GOIRAN: So it is basic training for a medical practitioner?

Prof. GEELHOED: Yes.

The CHAIR: On that basic training, would you be able to provide a copy of the module that you referred to in your answer?

Hon ROBIN CHAPPLE: Statistically, is there any evidence from the medical fraternity—doctors—that a patient has passed away because of the dose of double effect? I do not mean because of some deliberative action; I am talking about where a dose of medication has been given to relieve suffering and death has occurred because of that. Is there any statistical information?

Prof. GEELHOED: I would not think so, just because that would be so difficult to collect and interpret, but also, as I was saying before, this is thought to be standard medical care, where people are trying to do their best and so on. Clearly, if someone got 10 times the wrong dose by mistake or something like that, that would clearly be an incident and so on. But often with these cases, for the very reasons we have talked about, it is possible you do not even know. You are trying to do the right thing by the patient, and because you cannot relieve symptoms, as I would understand, you might push it a bit more than you thought. People's ability to absorb these things varies anyway, so trying to pin down in the end when the patient dies how much was one and the other would be impossible. I do not think it is a clear incident. The principle is clear and everyone is trying to do the right thing by the patient, the family and so on.

Hon ROBIN CHAPPLE: I am not doing this to be in any way prosecutory.

Prof. GEELHOED: No; I understand your interest. In answer to your question, I just do not think you could document that or accurately say yes or no.

The CHAIR: In relation to double effect and the provisions in the Criminal Code, on what basis is this distinguished from conduct that might be otherwise a homicide offence? I think you have probably answered that.

Dr BRADLEY: Legal advice is that I do not respond to that question.

[2.40 pm]

The CHAIR: Is the relationship between medical professionals and patients compromised by the doctrine of double effect?

Dr BRADLEY: In my personal opinion, I do not believe so. I think any open discussion about these important issues actually benefits the relationship between doctors and their patients.

The CHAIR: We have asked questions around monitoring incidents and keeping statistical data, so we have obviously canvassed that. Are there concerns that vulnerable people are being influenced or coerced into consenting to dangerous levels of pain relief?

Dr BRADLEY: We do not have any data to confirm that.

Prof. GEELHOED: There is nothing to suggest that from all the stats that comes across my desk; it is not an issue.

Hon NICK GOIRAN: Before we move on, what is meant by dangerous levels of pain relief?

Dr BRADLEY: I do not know. That is a question we were asked, not something that we have written.

Hon NICK GOIRAN: I just think it is fair if you feel that, that you should express that to the committee, because if the committee is asking about dangerous levels of pain relief and that is not clear to you, it is only fair for you to indicate that.

Prof. GEELHOED: Yes, that is a good point. I took it to mean in the context of the conversation we were having around the double effect and so on that "dangerous" meant easing into areas where that may be causing it, so that is what I took to mean.

Dr BRADLEY: Yes, I took the same.

The CHAIR: In this instance it is where there is the possibility of shortening death—would be potentially dangerous levels.

Are there any concerns that substitute decision-makers for vulnerable people are being influenced to consent to dangerous levels of pain relief or are exploiting their position in their own interests?

Dr BRADLEY: I am not aware of any data around that.

Prof. GEELHOED: No.

The CHAIR: How does the department ensure patient safety in these cases?

Dr BRADLEY: As per my response to the other circumstance about patient safety, so it is to do with death reviews.

Hon Dr SALLY TALBOT: If I may, we have reached the end of the list of questions that you have seen, and I just want to return you to the second question, which was about the physical process of dying. I respect your decision not to answer the question because of legal advice you have received, but I wonder whether we can just tease a little bit out here. We have talked a lot about morphine and the fact that morphine in and of itself does not hasten the patient's death.

Dr BRADLEY: When used appropriately and titrated properly, yes.

Hon Dr SALLY TALBOT: First of all, let us talk about morphine. Is morphine ever prescribed in either your empirical knowledge of the field or in the role that you play in the health department? Is it ever administered in amounts that are not compatible with your regime of appropriately titrated doses?

Dr BRADLEY: In a way "morphine" we use as a term but actually we refer to any opioid-based medication, so I think we would refer to all of those in that setting.

Hon Dr SALLY TALBOT: That was my next question, so if you want to take that on as well, let us spread the field, because "morphine", as you said, is a generic term.

Dr BRADLEY: Yes, it is one form of opioid-based medication and we, obviously, use quite a number of opioid-based medications to manage symptoms. We use them for pain relief but we also use them for breathlessness; they are used in those circumstances. From the point of view of the doses used, from my own personal experience and my own personal use, I would never use them in a way that was not titrating them appropriately and based on safe prescribing guidelines. That would be based on individual patients and we base that on whether they have had exposure to opioid-based medications before. If you have already had opioid-based medications, you often will find that patients will be able to tolerate higher doses and, in fact, require higher doses to manage their symptoms, but not always—they may still start off at the bottom. It is also influenced by other medical conditions that the patient has, so a very frail 94-year-old person would require much smaller doses than a fit otherwise healthy 24-year-old. You would have to adjust the doses based on the individual patients as well.

Hon Dr SALLY TALBOT: Within the prescribing protocol, sticking very tightly within your parameters of appropriately titrated doses, you are saying that you are not aware of any practice prescribing above the titrated doses, but that itself is a contextual thing, so what is an appropriately titrated dose for one patient may be inappropriate for another?

Dr BRADLEY: Absolutely.

Hon Dr SALLY TALBOT: One could, as the practitioner, administer a dose that was in the guidelines, within the protocols, perhaps for a 24-year-old man, but give it to a 94-year-old person who weighs 45 kilos, and still be within those guidelines?

Dr BRADLEY: Our guidelines are not dictatorial in that they would always say that you need to base them on looking at that patient and their individual circumstances. It may suggest that you start at a particular dose, but then it would clarify that you would adjust that dose based on the patient that you have in front of you.

Hon Dr SALLY TALBOT: Are we now talking about morphine and derivatives?

Dr BRADLEY: Yes, absolutely.

Hon Dr SALLY TALBOT: So, we have covered opiates or derivatives in that?

Dr BRADLEY: Yes, that is right.

Hon Dr SALLY TALBOT: Now let us go on to other pain-relieving or sedating medications. I want to return first of all to your comment about morphine et cetera and that in and of itself it does not cause death. Is that the case also with these pain-relieving or sedating medications?

Dr BRADLEY: Yes, in my clinical opinion that is the case. If they are used in appropriate doses and titrated appropriately, they are safe medications to use.

Hon Dr SALLY TALBOT: So, there is nothing in the list of drugs, albeit that they are umbrella terms, even breaking them down to their smallest parameters, that in and of itself causes death?

Dr BRADLEY: Unless they are used in doses that are not appropriate. All of them would cause death if used in inappropriate doses.

Hon Dr SALLY TALBOT: When we are teasing out that notion of “appropriate”, you are saying that for each and every patient there will be a maximum dose that is prescribed by protocol above which the practitioner would never go?

Dr BRADLEY: No, protocol would not have a maximum dose, because it would be titrated based on that patient’s individual needs. Say, if we used morphine, and I will use an example of a number to help you, if you are looking at a 94-year-old lady who has pain from her lung cancer, you give her 2.5 milligrams of morphine and that would be enough to manage her symptoms. That would be appropriate and you would not need to go any higher than that necessarily, but you may do. It may be that someone needs 2 000 milligrams of morphine to help manage their pain.

Hon Dr SALLY TALBOT: That would be a 24-year-old rugby player?

Dr BRADLEY: Potentially, but it can be surprising and it can also be 94-year-old ladies as well. It is very much individual and that is where the titration comes in; that is, we would always start at the lowest appropriate dose for the person and then titrate up until we either get good symptom control or we recognise that the person is not getting good symptom control for a variety of reasons, and that may be that it is not the right medicine for them. It may be causing symptoms. It may be that when we look at the symptom they are getting, that morphine or morphine derivatives are not actually the right medication to manage that symptom, and then we look at changing to a different medication.

Hon Dr SALLY TALBOT: Nevertheless, under this heading of the doctrine of double effect we are referring to the hastening of death. Why are we doing that?

Dr BRADLEY: The doctrine of double effect as an ethical term does not specifically relate to the hastening of death. Obviously, in this setting we are using it to talk about opioid-based medications with the theory, which was historical, that palliative care used these medications or that health professionals use these medications for symptom control, but that they may hasten death. I think emerging evidence is that actually these medications, so long as they are used appropriately, do not hasten death.

Hon Dr SALLY TALBOT: So, we do not need to call on the doctrine of double effect in relation to opioids and derivatives and other sedating and pain-relieving medication?

Dr BRADLEY: No, that is exactly right, assuming they are used appropriately.

Hon Dr SALLY TALBOT: Do we ever need to call on the doctrine of double effect for any treatment that is administered under the palliative care heading?

Dr BRADLEY: Yes.

Hon Dr SALLY TALBOT: What are they?

Dr BRADLEY: Again, it is very individual. Patients may choose to take on a treatment that will control their, say, cancer, for an example. They may choose a treatment that has risks associated with it. Obviously, it is a small risk, but it is potential, and so they may choose to take that treatment on. We use other medications. So say we use medications to control calcium levels in patients when they are getting symptoms from having too high a level of calcium, and those medications that we use have potential side effects that may potentially lead to the person dying sooner than otherwise. It is a potential side effect of that medication. We would discuss it with the person, but if that is what the patients feels is in their best interests, that it gives them quality of life, it is a risk worth taking.

[2.50 pm]

Hon Dr SALLY TALBOT: It seems to me that there is a qualitative difference in the two cases that you have just described. Surely the decision to go with a certain type of cancer patient is one that will be made by the patient and the oncologist, not by the palliative care provider?

Dr BRADLEY: That is right, but some of our patients will still be receiving oncology treatment.

Prof. GEELHOED: I think what we were talking about before was probably based on a generation or so ago, when morphine was given but we did not have pumps or that sort of thing. It was much less, you know, precise—scientific. So the risks of getting it wrong—that is when that principle became quite clear. As we have evolved, with pumps and a much better understanding of how these medications work, the circumstances where this happens are much, much rarer now, but probably right at the extreme—I think Kim would agree. If you are right at that stage when you are factoring in everything about that particular patient and their circumstances, you are still at the very edge of what you can give, then you are reassured by the fact that this is a patient who will be dying in the next day or two. You know, you are comfortable to sort of push it that bit more if it is going to help relieve symptoms. But it rarely happens these days.

Hon Dr SALLY TALBOT: Just so that I can be clear, are we back to the opiates and derivatives?

Prof. GEELHOED: Yes. Sorry; I was talking about that. I would think that the circumstances are much less common now than in the days when you were just giving injections every whatever—so many hours—and a big whack at one time could, you know —

Hon Dr SALLY TALBOT: When the treating practitioner is faced with a situation where everybody knows it is a terminal case and the person is going to die within the next 48 hours, is that the occasion on which you might go beyond the appropriate titrated dose?

Prof. GEELHOED: If they were suffering and you felt that could relieve their suffering, yes.

Hon Dr SALLY TALBOT: Which is when we do need the doctor in a double effect?

Prof. GEELHOED: I deal with this day to day, but that would be my understanding, yes.

Dr BRADLEY: I think it is an incredibly difficult area to get your head around, because we just do not know when someone is going to die.

Hon Dr SALLY TALBOT: You can often shed light in dark corners if you are prepared to go far enough down the burrow.

Dr BRADLEY: Because we do not know when someone is going to die, it is obviously difficult to know whether something is being brought forward by a small amount. If we know that it is imminent, whether it changes by an hour or a day can be incredibly difficult, even with good-quality research

to work that out, because, obviously, it is impossible to turn back the clock and try something different and see what happens.

The CHAIR: Do members have any other questions on this before I close the session?

Mr J.E. McGRATH: I just want to make a quick comment. I think that is the crux of the whole thing. Obviously, the best doctor in the world does not know when someone is going to die precisely. I know people who have been sent home and they have been told that they have six months to live, and four years later you still seeing them walking around. It is an impossibility for the medical profession to make decisions that can be so accurate.

Prof. GEELHOED: You have got to stay humble.

The CHAIR: Thank you for your evidence before the committee.

Hon NICK GOIRAN: Chair, are you closing the session?

The CHAIR: Yes, this session, I am.

Hon NICK GOIRAN: I notice that we will still have the session on health professionals working in palliative care.

The CHAIR: Yes. In the break, we had a discussion with Amanda Bolleter. We will try to get those questions to them to respond to you, so that we can move onto the next session that was due to start at 2.30. If the committee is happy with that, we can forward that for a response.

Hon NICK GOIRAN: Will that also apply to the second section which was to deal with palliative care for older people with chronic diseases?

The CHAIR: Yes. Part of my wrapping-up statement is that we will forward any questions that were not asked for a written response.

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. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. The committee will write to you with the questions taken on notice during the hearing. In addition, we will include the proposed questions that we were unable to address due to time constraints. Thank you very much.

Hearing concluded at 2.54 pm
