

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 FOUR

Members

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

Hearing commenced at 3.58 pm**Dr LISA MILLER****Clinician, Consultant Liaison Psychiatrist in Cancer and Palliative Care, WA Cancer and Palliative Care Network, examined:**

The CHAIR: I will open the fourth session for today and I would like to welcome Dr Lisa Miller. 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. We have Hon Robin Chapple, MLC; Hon Nick Goiran, MLC; Hon Col Holt, MLC; Simon Millman, MLA; Reece Whitby, MLA; Dr Jeannine Purdy, our principal research officer; John McGrath, MLA; and Hon Sally Talbot, who has just stepped out shortly. 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 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 you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. Would you please introduce yourself for the record; and do you have any questions about your attendance today?

Dr MILLER: My name is Dr Lisa Miller. I am a dual-trained liaison psychiatrist and palliative medicine specialist with a fellowship with the College of General Practitioners, although my predominant role for the past six years has been as a consultant liaison psychiatrist at Sir Charles Gairdner Hospital and for the past 11 years as the lead clinician in the Psycho-Oncology Collaborative of the Western Australian Cancer and Palliative Care Network. I have particular subspecialty interests in the mental health care of people with cancer and with other palliative care needs, and I have a particular subspecialty interest in the care of people with behavioural disturbance in the context of primary brain tumours and around the care of that group of patients at the end of life. I have also previously been a representative on the Cancer Australia working party for the guidelines around the management of suffering in the setting of cancer. I think I have been invited along today to try to offer a clinical perspective around the needs of people whose care sits at the interface of health and mental health. So there is one particular clinical case that I thought might help to illustrate some of the issues that are potentially relevant.

[4.00 pm]

The CHAIR: Before you give us some case studies, could you, probably for my benefit, just give us an outline of what the Psycho-Oncology Collaborative is?

Dr MILLER: So psycho-oncology is essentially a term that encompasses the many disciplines and settings of care that are involved with attending to the psychosocial wellbeing of people at the end of life. My particular role as the liaison psychiatrist—so a doctor who works specifically in this field—is to try to encompass both in terms of representing the individual patient experience and the assessment of that, but also to attest and to try to provide some strategic planning at a service level, at a workforce training level, around understanding the biological, psychological, social, spiritual and cultural factors that can contribute to people's wellbeing in the setting of their cancer care.

The CHAIR: Thank you. Did you want to outline some case studies for the committee?

Dr MILLER: Sure. Because it is not uncommon for me in my clinical practice to meet people who have expressed a wish for hastened death—that would be a basis for a referral to me; I am the

person who people come to see, I suppose, in that respect—one of the things that I would want to emphasise from my clinical experience of looking after that group of people is that we should distinguish the expression of a wish for hastened death from specifically a desire to end life or, in this context, what might sort of transpose to a desire to pursue, say, physician-assisted suicide as a mechanism of ending life.

There is a degree of academic research in this area. One particular researcher Monforte-Royo defines that an expressed wish to hasten death is generally a response to multidimensional suffering, and it is acknowledged as a phenomenon that tends to vary over time. It depends on the stage of circumstances in which an individual person might find themselves, and is reflective of a range of domains—physical, psychological, social, existential and spiritual. The wish for hastened death can hold different meanings for different individuals and it can serve functions other than to communicate a genuine wish to die. So, there is a very important need to individualise the assessment and to hear the story of the person who is coming to see us to understand what underpins that expression of that wish.

So, to use a particular clinical example—and I have sought permission from the patient involved to discuss the case, although I will intentionally de-identify the case to protect the privacy of that individual. This is a case from this year, a middle-aged man. I received a call from the medical oncologist saying, “Lisa, I’ve seen a man in my clinic today. He is two treatments into a treatment of curative intent, chemo and radiotherapy treatment, for a head and neck cancer. He’s very distressed and he has indicated to me today that the burden of suffering of his treatment—it is not possible for him to continue to endure this and he would like to cease treatment. But I’m actually really concerned that he might be depressed. Would you mind seeing him?”

I have a single clinic. It is the only specifically funded cancer liaison psychiatry clinic in Western Australia. It had a month waitlist, but the urgency of the situation meant that I made specific time to be able to see this fellow within two days of receiving that contact. I then met with him and with his wife and he certainly appeared very low in mood. I asked him to tell me a bit more about his experience. He described his discomfort on swallowing. He had lost a substantial amount of weight, approximately 10 kilograms, over the course his treatment. He felt that this was unendurable for him. He really felt that there was no point in continuing to live if life meant living like this. So as a process of taking an individualised history from him, finding out a little bit more about him as a person, the things that were important to him, he was able to actually articulate that there was a range of physical symptoms that were contributing to his significant distress, particularly that pain was making it very difficult for him to eat. He felt that if continued treatment meant that he would continue to need to experience this burden, that that was clearly not an option for him. But he actually also was very much wanting to be helped at the same time, so I certainly did feel that he was suffering from a major depressive disorder. I also felt that he was suffering, because I am a palliative medicine specialist by training as well, that he had severe mucositis—so inflammation of the very sensitive mucosal linings that can happen with chemo and radiotherapy for head and neck cancers—and that his substantial weight loss and the associated malnutrition that he had developed was also likely to be a feature contributing both to his low mood, his fatigue, and also to his inability to actually improve his nutrition. Once people slip into starvation syndrome, it is very difficult for them to restore their own nutrition.

So in the process of speaking with him and with his wife, he was agreeable to me starting an antidepressant medication that I know to be tolerable for people who are undergoing cancer treatment. It comes in a particular soluble form that makes it less difficult for people who are having trouble swallowing. We organised for some specialist palliative care input, but also I was able to talk to the radiation oncology registrar through optimising some of his medication so that he could

tolerate those in a form that was manageable for him, as opposed to trying to swallow tablets. In addition, I was able to organise a dietitian referral to work on some supplements to improve his diet. Ultimately, we actually did organise an inpatient hospital admission for some nasogastric feeding to improve his nutrition.

Within two weeks, he was already exhibiting substantial improvement in his depression, his symptom control was better and he was feeling that he was sleeping better and, as a result, he was managing his emotions during the day a little better. I was then able to follow him up and advocate on his behalf, on seeing him on a number of occasions over the next two months as he completed his treatment. Six weeks ago I saw him, big smile on his face, and he said, “Lisa, I’ve just been told my cancer is cured. I’m the best I’ve felt in 10 years. I know I still have a way to go in regaining some of my weight, but I’m back at work. I’m really looking forward to Christmas with my family.”

So, I bring this case because I think a nuanced assessment of an individual’s expression of their suffering that actually then drills down into the biological aspects of that, the psychological aspects of that, the social aspects of that, the spiritual aspects in terms of people’s sense of loss of meaning, loss of role functioning, loss of purpose et cetera, is actually really crucial, both in terms of reducing their burden of suffering—I am a doctor and that is my role—but also very important for the experience of his family.

I would be concerned that sometimes we have a habit of introducing legislation but not necessarily considering the resource implications of introducing legislation. I would be concerned to see a situation whereby the waitlist to see a specialist liaison psychiatrist for an assessment of decision-making with respect to pursuing, say, physician-assisted suicide, might mean that the waitlist for that clinic was in excess of six months long, and the ability to see someone in a timely fashion for a therapeutic assessment might mean that they then elected to withdraw from treatment so that their curable cancer became incurable and they were then in a position of requesting physician-assisted suicide down the track to deal with their suffering.

[4.10 pm]

I appreciate that sounds a little simplistic but I think being able to actually separate off a therapeutic assessment from a medico-legal assessment is actually really crucial in my work. It is crucial to be able to see someone and hear their story, try to get a good understanding of their individual experience, the things that are most meaningful for them and the most distressing for them, and then actually to develop a plan collaboratively that is individualised to their needs, along with other health professionals, and to try to validate their experience of suffering and try to provide exquisite symptom control, which is often reasonably specialised for people with particularly very complex pain issues. This can counter their sense of isolation, that they are alone in experiencing their phenomena, and certainly to try to help them hold on to a sense of meaning, even if that might be reframed from what they have previously experienced—their sense of value—really to just try to explore some of those questions with them in a curious way and in a supportive way. Certainly, with the nature of assessment of decision-making in my business, particularly because I look after people with primary brain tumours, it is important to understand that decision-making exists on a continuum, but people move backwards and forwards along that continuum depending on the nature perhaps of their tumour, the side effects of treatments that they might be experiencing, the progression of the underlying disease process, and the response to treatments. The notion that it is a black and white sort of idea does not map to the reality of what I see. But I can see that it would also be very difficult, if I were in a position to be someone who is undertaking assessments, the due diligence that would be required for such an assessment in terms of getting a sense of all the issues that might be impacting on that person’s level of their expressed wish, and then trying to determine

what needs have been met and what needs are not met, and at what point does my assessment become one of a therapeutic intervention. What happens if that person says, "Can I come back and see you to discuss this later?" In terms of resource implications, I think we probably need to be aware of those as broader issues, and certainly access to specialist liaison psychiatry and, indeed, to specialist palliative medicine does vary around the state.

Hon ROBIN CHAPPLE: Thank you very much indeed. Regarding your comments about depression in this period, I worked in the mining industry and I have lost 60 per cent of my colleagues to cancer, which seems to be the norm these days. I have dealt with a lot of them, and I found that chemo, as a program, leads to immense depression. Is this normal?

Dr MILLER: It would depend on the individual, the nature of their cancer and the chemotherapy regimen, but there are some treatments that are known to have potential depressogenic side effects, and there are other factors that also contribute to low mood. Again, I suppose in my work I try to distinguish between demoralisation and depression. That is quite a crucial distinction. Certainly when people feel that their resources are overwhelmed, they will often become demoralised, but that would be a different clinical entity to depression, although you can be both depressed and demoralised simultaneously. It is quite a nuanced assessment. It is something that I still continue to develop my understanding and my skills of, and will often still call upon a colleague to discuss a case or to ask for a second opinion. It is a fairly small group of psychiatrists who specialise in this field. We probably would not seat everyone at the table, but sometimes we need to actually call upon colleagues interstate to discuss particularly challenging scenarios because of the implications and the burden of suffering.

Hon ROBIN CHAPPLE: You were saying that there is that difference between depression. How do you determine that and what are the sorts of percentages, in your view?

Dr MILLER: I could not give you percentages. I think it has not been sufficiently studied for us to have the robust data around that, although some work is happening at Monash University to look at that. Sometimes there is also a need to see someone on multiple occasions to actually distinguish the difference between acute distress or dysphoria and side effects that might be related. All of us when we are sleep deprived will often exhibit a degree of dysphoria or mood lability. Certainly if people are having treatment with steroids, that can have substantial effects on their mood. If there are other treatments, they might be contributing. Being able to see a person on multiple occasions is really important to get a sense of what of this varies over time and fluctuates and what of this is actually core and central, even just for that person. It is important to get a sense for that person, what are their priorities, what is the consistent sense of them through this? Certainly in situations where I have been involved in someone's care at end of life where there have been complex mental health issues, having an understanding of some of their priorities, their sense of core issues that they have expressed to me as being important to them, has also been important in informing the sort of care that we can provide for them at the end of life.

Hon NICK GOIRAN: Dr Miller, thanks for your evidence for the committee today. It has been most helpful, not the least of which the case study that you gave us. Are you able to advise if it is common for those with a physical disability or a physical illness to experience psychological sequelae?

Dr MILLER: I can provide some general data in that, as a liaison psychiatrist, I care for people at the interface of physical and mental health, and I work in a general hospital around attending to people's psychological and psychiatric wellbeing in that setting. General data around liaison psychiatry would suggest that around 40 per cent of people in a general hospital setting may be experiencing some degree of significant mental health comorbidity along with their physical health morbidity. Certainly, in the cancer setting, the specific data around people who would meet

diagnostic criteria for clinically significant psychological distress—so, meeting criteria for a formal diagnosis—would be, depending on the study quoted, between 20 and 35 per cent. So, comorbid depression with cancer and comorbid depression with other advanced illnesses, is common.

Hon NICK GOIRAN: But the percentage for those with psychological secondary conditions, on top of cancer, is less than for ordinary physical disability?

Dr MILLER: It depends on what population you are looking at. The general hospital population would include delirium. Quite a significant proportion of people in a general hospital could be identified as suffering delirium to some extent at some point during their admission, and that obviously has implications in terms of decision-making et cetera. But overall, cancer often provides sort of a reasonable cohort of people with a significant burden of physical illness—somewhere between the 20 to high 30s percentage.

Hon NICK GOIRAN: And depression would be included as one of the subsets of that secondary psychological condition?

Dr MILLER: Yes.

Hon NICK GOIRAN: What about this concept of demoralisation? Is that something different from depression?

[4.20 pm]

Dr MILLER: Demoralisation has been a construct that has been discussed for some decades now—introduced first of all by Viktor Frankl—and is not unique to the healthcare setting; people can become demoralised in many settings, including the workplace. But with respect to health care particularly, there is an endeavour to try to define demoralisation as a diagnostic entity, because it is certainly something that myself and my cancer and palliative care psychiatry colleagues would see reasonably frequently and would seek to distinguish from depression, so we would tend to talk about an adjustment disorder with demoralisation or perhaps a major depression with demoralisation. It is usually defined as being, again, a sense from people, expressed by them, that their needs have overwhelmed their resources, that there is something fundamentally of themselves—that they are in a place of suffering.

Hon NICK GOIRAN: So was that patient of yours that you gave us in the case study depressed or demoralised?

Dr MILLER: He was depressed and he was demoralised. I am sorry; I know that is a bit of a muddy distinction. He certainly met a full set of criteria for a major depressive episode, which is why I treated him with an antidepressant, which he responded very well to, but there were also features of demoralisation that related to the fact that he was having difficulty swallowing, could not sleep very well, had pain et cetera, and the sense of isolation that that created for him as well, so we were able to actually address features so that both his demoralisation and his depression were responsive.

Hon NICK GOIRAN: The last question is on countertransference. Can you tell us what that is and how patients might be protected from it?

Dr MILLER: I might need you to explain that in just a little more context.

Hon NICK GOIRAN: In terms of protection.

Dr MILLER: Protection from?

Hon NICK GOIRAN: Maybe let us start with countertransference. Are you able to tell the committee what that is?

Dr MILLER: I will do my best. Countertransference came originally from the psychoanalytic literature and relates to the feelings that an individual generates. The context was as a therapist towards the person, in essence. There is a transference from the person to the therapist, and a countertransference back in the other direction. I think I know where you might be going with this one, if it is all right for me to stretch it a little. Sometimes, people with challenging needs might generate a strong response either at an emotional level or even expressed at a behavioural level in people around them, where it generates a strong response. Sometimes, although it is not the classical meaning of the word, we sometimes talk about countertransference of health professionals towards challenging patients; I am not sure if that is where you were going with that one.

Hon NICK GOIRAN: Yes. So I just wonder if there is anything that can be done to protect a patient from that happening. The therapist might be feeling demoralised and then counter-transferring that back to the patient, or is that just something that we have to live with because we are humans and not robots?

Dr MILLER: I think I would be offering an opinion rather than a robust answer to the question. In essence—if we are talking in a health professional context, because countertransference is not unique to psychiatrists—certainly good training of health professionals and also very good opportunities for reflection and supervision in a formal sense of being able to actually—a lot of the work we do is very challenging. It generates strong feelings for people, so it is actually really important so that people deal with their responses in a safe and healthy way and they do not take it home and they do not bring it back to work. It is really important for them to have a safe place to go to to actually process that with a senior colleague et cetera or a formal supervisor, as we would say in a psychotherapy sense. But certainly there are other structures, like Balint groups or reflective groups, where people might take those cases, a peer review et cetera, to say, “Yes, this was my very challenging case for this week”—or this month or this year—“and this one’s really staying with me and I need a place to come and talk about this.” But that is a way of actually trying to make sure that those feelings, instead of sitting in the unconscious level, are actually brought into the conscious level and then discussed in an exploratory and robust way.

Mr J.E. McGRATH: I was just going to say that the luckiest thing for that patient was that his oncologist referred him to you, which raised with me a question. We all know of people who have been diagnosed with cancer. A lot of people say, “Well, I’ve just been given the kiss of death”, and things like that, and it must be very traumatic. But how many of those people would have the good fortune to be referred to a professional like yourself or in your field? There would be a lot of people out there who would probably have to handle it on their own, maybe with the support of family and maybe without the support of family. It must be a very difficult space for a lot of people to be in.

Dr MILLER: Very much so, and I think that is why, for the last 11 years, I have been the psycho-oncology collaborative lead for the WA Cancer and Palliative Care Network because I am very passionate about care that attends to the psychosocial wellbeing of people not only with cancer, but with other advanced illnesses. We get a number of neurological conditions that have a substantial burden of suffering that I have not specifically discussed at this juncture. I think I would be reticent to try to make a comment about the number of patients who do not get access; I think, rather than offer an opinion, I could provide a quote from a submission to the Joint Select Committee on End of Life Choices from the WA branch of the College of Psychiatrists. Would that be useful?

Mr J.E. McGRATH: Yes, thank you.

Dr MILLER: Okay. Within psychiatry there are a range of specialisations. It states —

While all psychiatrists have training in working with co-morbidity, consultation–liaison psychiatrists specialise in the treatment of mental illness in the context of physical illnesses. An important component of the consultation–liaison role is in supporting medical services and staff in providing treatment that encompasses mental health.

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It is of ongoing concern to the WA Branch that consultation–liaison services are underfunded and are therefore not sufficient to meet the needs of the population. Consultation–liaison is not only underfunded in tertiary hospitals, it is practically inaccessible in other service settings.

Outside of the public hospitals there is no access to public liaison psychiatry services for palliative care patients. Given that the majority of palliative care patients are cared for at home or in a hospice setting, the majority of patients have no access to this care. This is significant as a large portion of these patients have either untreated mental health comorbidities or psychiatric side effects of their terminal illness or the treatments provided for these illnesses.

Mr R.R. WHITBY: Dr MILLER, my question is along the same lines. How many psycho-oncologists, if that is the correct term, practise in Western Australia?

Dr MILLER: In the public system, I am the only psychiatrist dual-trained in psychiatry and palliative medicine. My substantive position is as a liaison psychiatrist. I do one session per week—so, four hours—specialising in cancer liaison psychiatry at Sir Charles Gairdner Hospital. That is not a service that is accessible necessarily for patients whose care is outside Sir Charles Gairdner Hospital. There are other liaison psychiatrists in public mental health services around Western Australia, and many good liaison psychiatrists, who also are used to seeing people with serious illnesses and cancer, who might, from time to time, ring up and say, “Just wanted to check, does this particular cancer treatment have particular side effects?”, because that is reasonably sub-specialist area of expertise.

[4.30 pm]

I would look after the bulk of people with significant behavioural disturbance or mental health comorbidity in the setting of primary brain tumours because that service is based at Sir Charles Gairdner Hospital. That is specific to psychiatrists, so that is sort of talking about doctors whose expertise is in this field. There are also a number of specialist trained psychologists who work in this field, most of whom are based at the WA Psycho–Oncology Service, which is housed on the QEII campus but provides in-reach at Sir Charles Gairdner Hospital and Fiona Stanley, and also provides an outpatient service accessible for people around the state. So there are, I think, four full-time equivalent psychology positions there, but I would need to clarify the specific figures.

Mr R.R. WHITBY: I think you gave an example of the middle-aged man who sought your assistance. It was a referral that managed to jump the queue, so to speak.

Dr MILLER: That was a call from a medical oncologist who has my phone number in speed dial!

Mr R.R. WHITBY: The picture you are painting is that there is an issue here that there would be other gentlemen and women like him who may indeed have not received that attention and treatment.

Dr MILLER: I would be concerned that statistically Western Australia is no different from other centres around the world where there has been specific sort of examination of frequency of comorbid mental health issues. So therefore, given that I am not seeing all those people, and my

colleagues who are liaison psychiatrists are not necessarily seeing all those people, I think there is likely to be unmet need.

The CHAIR: I have a question relating to one of your earlier comments. You said there is a difference between therapeutic assessment and a medico-legal assessment. What is a medico-legal assessment?

Dr MILLER: In that instance, in terms of looking at some of the models that have been proposed in Victoria around assessment for—“suitability” is not the right word, but essentially for —

Hon NICK GOIRAN: Eligibility.

Dr MILLER: Eligibility—thank you very much—for pursuit of voluntary euthanasia or physician-assisted, there have been some efforts to define what that assessment should look like. The process is essentially one that will have therapeutic elements to it in terms of trying to exclude biological factors that might be contributing—psychological factors, social factors et cetera. But if someone has come and the referral request is essentially with a specific question, “Is this person eligible for this process?”, it is what happens if you say, “Actually, I do think you are depressed”? Who provides further care for that person? Do you start them on an antidepressant or not? Do you say, “I think you should go and get some care”? If they need good symptom control, who do you refer them to? In terms of actually an idea that it would be a simple one-off assessment, I think it probably does not map to the nuance of the complexity of these sorts of assessments. We are talking about people with complex issues that require nuanced understanding and individualised care planning, and potentially might need collaborative care from a range of health providers. Certainly in terms of psycho-oncology, I would also include specialist social workers, palliative care social workers, oncology social workers and other allied health professionals, including senior nurses, who play an important role in providing psychosocial support to people with cancer as well. So it is more than just the pointy end. I think the bulk of psychosocial care of people with cancer actually happens at that front line. But there is a need to make sure that those staff are trained and supported, and that they then have a very clear pathway of referral for escalating concerns about someone that they might be worried about: Who do they send them to? What happens then? What is that process? Where do things go from there?

Hon COLIN HOLT: On a similar line, I want to go back to your case study, and maybe I will make some assumptions that you can correct me on. I assume that the treating oncologist was treating for a curative treatment, so he thought he could cure the cancer that he had, and yet the guy was obviously having some difficulty sorting in his own mind what the best way forward for himself was with his treatment, so the oncologist referred him to you. You assessed him as being depressed, and you treated his capability symptoms, if you like, so that he could make a decision more in line with a curative treatment, I assume. The assessment you make about his capacity is kind of separate to the treatment he decides to take—would that be correct—because you can make sure that he can think straight?

Dr MILLER: Again, I will try to sort of answer. I am not personally attached to the outcome of what he chooses to do. What I would be concerned about is to make sure that I firstly relieve his burden of suffering in whatever form that is taking for him—physical, psychological, existential. I would separate off that nuanced assessment—the therapeutic assessment—of hearing his story, validating his suffering, trying to kind of help him tease out the different elements to put into words this ball of distress, if you like, to try to actually drill down and organise it to some extent into a plan, and then to get a sense from him about, “These are our options at this point.” The question around decision-making I would see as actually being a separate one, and it is a very nuanced one in that I cannot force someone to have chemotherapy. There are more complex challenges around

assessment of decision-making in someone who also has a serious mental illness that are a whole other issue. In this instance, this was a fellow who had come essentially because he was distressed, and in listening to his story it transpired that what he was saying was that it would be better to die than to feel like this. He actually did not want to die, and so the care that was provided helped to reduce his suffering. He wanted to live; he just did not want to live with those symptoms. So it was really about trying to actually tease out a plan through that. That is quite separate to an assessment of decision-making, which is a much more complex and formal process.

The CHAIR: This chap was in active treatment?

Dr MILLER: Yes.

The CHAIR: He was not in the palliative care phase?

Dr MILLER: No. I think, though, I would say that with palliative care we would try not to be too—people can get benefit from good symptom control even while they are having treatment of curative intent; or if they have completed treatment for their cancer, they might still have symptoms that would benefit from good, exquisite symptom control. He was not in a palliative phase in the sense that it had not been determined that he had an untreatable cancer, where the focus of care was going to be on comfort-based measures rather than active treatment. But the concern I think from the medical oncologist was that she was concerned that his decision or his desire that he did not wish to complete treatment was actually rooted in his distress, and that she felt that that would be amenable to treatment.

The CHAIR: Any other questions?

[4.40 pm]

Hon Dr SALLY TALBOT: The situation you have described—I am sorry, I was called out of the hearing when you told the story, but I think I gathered enough from the last 15 or 20 minutes—is a depression. You diagnosed this person with depression and treated the depression and moved him into a different space. This is a depression clearly of the type that is caused by a situational event.

Dr MILLER: No; I think he probably had elements of that depression —

Hon Dr SALLY TALBOT: Right. That is what I wanted to tease out.

Dr MILLER: Yes, elements that probably predated, and I think that is the importance of a thorough history.

Hon Dr SALLY TALBOT: That he had not sought help? For.

Dr MILLER: That was incompletely treated, yes.

Hon Dr SALLY TALBOT: Was he already receiving treatment for depression?

Dr MILLER: Yes, but it was insufficient for the nature of his symptoms, so he had had past treatment and was on a background dose of an antidepressant medication that was insufficient to actually meet his symptom control issues at that time.

Hon Dr SALLY TALBOT: Would you still classify it as a kind of situational depression rather than a melancholic depression or an endogenous depression or whatever term it is you use for sort of existential depression?

Dr MILLER: I think you could argue that he was depressed and met full criteria for a major depression with melancholic features. I would not distinguish then about particularly the origin of that. I would say that he presented with a constellation of symptoms that would meet robust criteria. But he also had features of demoralisation; he had features of poor symptom control; he had features of poor sleep; and he was severely malnourished. All of those things were contributing to his dysphoria, if

you like—an unpleasant state. Part of that dysphoria was an incompletely treated major depressive disorder that had certainly worsened in the context of his —

Hon Dr SALLY TALBOT: Was he identified as a person with a mental illness who was now being treated by an oncologist?

Dr MILLER: No. There are lots of people who are receiving treatment for cancer and lots of other health problems who are also on antidepressants for treatment of anxiety or depression and are long term, and they are not routinely referred to me; they are often very well cared for by their GP. It was not even something that the team had necessarily been aware of in the course of his basic cancer care, but it was something that, as part of the history, was further elucidated.

Hon Dr SALLY TALBOT: Once he saw you.

Dr MILLER: Yes.

The CHAIR: Thank you, **Dr MILLER**, 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 by 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 any questions taken on notice and, in addition, we may include any proposed questions that we were unable to address due to time constraints. Thank you very much.

Hearing concluded at 4.42 pm
