

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
FRIDAY, 13 APRIL 2018**

SESSION FIVE

Members

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

Hearing commenced at 2.37 pm

Mr MURRAY ROBERT HINDLE

President, Dying With Dignity Western Australia, examined:

Mr STEPHEN ALEX WALKER

Vice President, Dying With Dignity Western Australia, examined:

The CHAIR: Hello and welcome, Mr Hindle and Mr Walker. I really appreciate you coming in to speak to us this afternoon. I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson; I am the Chair of the joint select committee. We have Hon Dr Sally Talbot; Mr John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that may exist. It is important you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing. Do you have any questions about your attendance today?

The WITNESSES: No.

The CHAIR: Would you like to make a brief opening statement?

Mr HINDLE: Yes, I would, thank you. I will read from it because if I do not, I will make a pig's ear of it!

As stated in our submission, DWDWA welcomes the establishment of this committee and commends the Western Australian government for their initiative. The joint select committee is also thanked for the time and effort you have devoted to this project in the past and in the months that lie ahead. I will devote my brief remarks to some of the reasons for our commitment to the cause of voluntary assisted dying, and my colleague Steve Walker will briefly refer to some aspects of our argument in support of future assisted dying legislation.

Dying With Dignity Western Australia started life as the Western Australian Voluntary Euthanasia Society and was incorporated in 1984. We changed our name two years ago to match changes made by other Australian societies to reflect a national common purpose. Our membership is 683 members with an average age of 77 years—and growing, I think. It would be fair to say that horrifying dying experiences aside, the reason they joined is a concern about their pending death and what control, if any, they would have over the process. We are also members of Palliative Care WA and support the provision of the best available palliative care for all Western Australians. We stand with PCWA in abhorring the thankfully diminishing tendency to offer and provide medical interventions that do nothing other than prolong suffering in the face of certain death. The debate surrounding the argument for and ultimate successful passage of legislation on assisted dying lies with two key words. The first is empathy, which, as you know, is the capacity to place one's self in another's position. The second is compassion, which is the emotion we feel when others are in need,

which motivates us to help them. If those who legislate on our behalf have the wisdom to put aside personal views and embrace empathy and compassion, they will find themselves in step with the wishes of over 80 per cent of recently polled Western Australians. Fundamental to the case in favour of any individual's right to an end-of-life choice is autonomy. The sufferer must have the right to choose, free from interference or coercion of any kind.

A few weeks ago, I was pleased to speak to a small international current affairs group of around 20 people. Before I gave my address, I opened by asking for a show of hands of those who believed it was their right to an end-of-life choice. All but two raised their hands in support. It was encouraging but not surprising to see the oft-quoted poll statistics were reflected in real life. Studies show that assisted dying has gathered momentum around the western world. Presently, over 200 million citizens have the right to a voluntary assisted death. Public opinion in support of doctor-assisted dying has for over four decades been supported by a significant majority of Western Australians. We maintain that it is a basic human right that a caring and compassionate society will allow its citizens access to a dignified and stress-free death at a time of their own choosing. It is up to those we choose as our representatives to have the political will and rigour to see our wishes realised. We are not here to preach, but respectfully suggest that a politician's role is not to impose their world view on their electorate but to reflect the majority view of their constituents. The late severely handicapped Professor Stephen Hawking once said, "To keep a person alive against their wishes is the ultimate indignity." Likewise, Professor Charlie Teo also said, "I am proud of my reputation of never giving up on a patient who still has the will to live despite what others believe to be an exercise in futility. I am equally as proud to support Dying with Dignity because the only situation that would be worse than not having control of your life is not to have control over your own death."

Thank you. I would like to hand over now to Steve Walker, who will briefly flesh out our argument. We look forward to any questions the committee may have. Please bear with us, as we came a little unprepared, as we were not provided with the expected list of questions. We will do our best.

Mr WALKER: Thanks very much. As Murray has just indicated, we do not have a list of questions. We contemplated how best we could say something briefly without all the eyes glazing over and, of course, we do not want to try and just reiterate or summarise what we have tried to say in our written submission. The written submission, as I guess is fairly apparent from it, draws heavily, and deliberately so, on a number of sources we identified. In particular, we think that neither we nor perhaps anyone else involved in this exercise would want to try to totally reinvent the wheel in the sense of covering exactly the same territory as was covered in the very comprehensive Victorian inquiry. We have not tried to traverse everything that they covered. We found their report very useful, very persuasive and full of substance. As I think we have said in the submission, whilst we do not agree with 100 per cent of the recommendations of the committee, nor with 100 per cent of the final version of the law that emanated from that inquiry through the working party and so on, nevertheless we found the process, the report, the bill and the act to be highly informative and useful, and we adopt much of what has been said. We have also referred quite specifically to the evidence given by Andrew Denton to the Victorian committee. I understand he may already have given evidence to you today.

The CHAIR: This afternoon.

Mr WALKER: This afternoon; so you can hear it straight from the horse's mouth. We found his style and content to be likewise very helpful and persuasive, particularly in addressing, in quite a down-to-earth and chatty kind of way if I can say so, the propositions that are so often put against voluntary assisted dying—the slippery slope and other similar arguments. I will not try to go into those but I just signal that we have found what he said there to be very helpful as well. Finally, the

DWD Victoria submission. You would not be surprised to learn, I guess, that we thoroughly endorse what they had to say to the Victorian committee. As I say, we have drawn pretty heavily on those sources and we have tried to make our written submission reasonably succinct.

We do not seek to, as I say, trawl through all of that again today. What we thought we would do quite briefly, in just a few minutes perhaps, is just to touch upon a few of the strands that are perhaps quite significant for this committee in terms of focusing on some of the key criteria that should be in voluntary assisted dying legislation. We have come up recently for ourselves with three articles, which we found to be useful and we did not refer to them because we did not know about them when we wrote our submission. Your staff have very kindly for me just now copied the three articles and I think they have copies perhaps for each of the members. I just want to touch on them briefly. One is “Physician-Assisted Suicide—Oregon and Beyond” from *The New England Journal of Medicine*. It would appear to be a well-written, professionally constructed and authoritative source. This is the oldest one, from 2005. In just a few pages—about three pages, it provides a useful overview of the operation of the Oregon law at that point and we commend it to you. As is said on the second page in the second paragraph, it refers to seven years of experience at that time in Oregon. In the second-last paragraph on page 2, the author tells us that the law has not had the dire social consequences that some opponents predicted. She says there is no evidence that it is being used to coerce elderly, poor or depressed patients to end their lives et cetera. I will not go through all of it, but we just refer you to it in the hope that you might find it to be useful. It refers to quite a few statistics at that time and, interestingly, it says on the third paragraph on page 3 that there is suggestive evidence that the widely publicised debate about the assisted suicide law and its enactment contributed to overall improvements in end-of-life care in Oregon. That, of course, is one of the propositions often put against such a law.

The second of the three articles also relates to Oregon. It is from the *Annals of Internal Medicine*. It is headed “Oregon’s Death With Dignity Act: 20 years of Experience to Inform the Debate” and it is written by Hedburg and New. This one is a 2017 article and it is full of interesting and quite comprehensive data. For example, on page 3, it sets out sex, age, race, ethnicity and all sorts of things and also end-of-life concerns among those who died from ingesting, as it says at the top of the table, a lethal dose of medication compared with Oregonians who died from similar diseases. This is, indeed, over a 20 year period. It refers, at page 2, to the participating physicians and it is interesting to see how many have participated in the scheme. It tells us right at the end, in the last paragraph that, since 1997, the number of patients and physicians participating has increased but remains low with fewer than 0.2 per cent of Oregonian decedents participating. We hope that would be of assistance as well.

[2.50 pm]

The third article we have asked to be copied is a longer one and it is written this time not by a doctor but by a lawyer, Jocelyn Downie, an academic. It is from the *QUT Law Review* and is headed “Medical Assistance in Dying: Lessons for Australia from Canada.” It is a most interesting article. It canvasses at a little bit of length, the three major developments in Canada—the Quebec legislation, the Canadian Supreme Court case that came from BC, and then the Canadian law that grew out of that litigation. It gives you quite a useful history about all of that and it is specifically, as the title indicates, aimed at drawing lessons from the Canadian experience. For ourselves, we found the Oregon act and the Canadian law to be instructive and helpful. We thought that we would just quickly, if I can, set out some of the points that those laws make about some of the key issues that you may wish to deal with. The first of those might be whether the law should require a finite period before death for a patient to qualify. It is well-known that in Oregon, the time period is six months. In Victoria, the inquiry report, as I recall it, recommended 12 months; the act, as it ended up, was six months,

but 12 months for those with I think neurodegenerative diseases, recognising that they form a special category. We respectfully suggest that that is very much a minimum sort of standard. In other words, we would welcome, of course, the introduction of any VAD law, but we would suggest, respectfully, that there need not be such limits and certainly not such tight limits in order to have a law that works well with appropriate safeguards. We note that in Oregon, curiously, the origin of the six-month time limit had nothing to do with principle or even research in terms of what would be an appropriate time before death to fix on. Rather, the articles tell us that—I can find the reference for you if you want—that the six-month time limit curiously came from health insurance requirements, yet it was fastened on, in the end, in Victoria. So there is nothing magic about six months and we would suggest that if a time period is to be fixed, it would be better to be set at 12 months or two years. Alternatively, one could have, perhaps, if one insisted on a time limit, a 12-month limit with a longer one—perhaps two years—for neurodegenerative diseases.

Better yet, we would suggest the law should simply, as Canada does, specify the normal, basic requirements in terms of the level of intolerable suffering to be assessed—crucially, we say by the patient, and really all the models accept that. It is not for the doctors to determine the level of suffering; it is for the patient. Then conditions like if the illness or disease is advanced and progressive and that the patient has been informed of other treatment options including palliation and so on but as far as illness is concerned, it is enough if the patient is seriously ill or perhaps if death can be reasonably foreseen. That, I think, is where Canada ended up. It avoids the rather desperate and difficult need to fix upon an arbitrary length of time that has no real connection to anything of importance in the debate. That is an issue that we thought we would seek to flag today. We particularly would want to emphasise that Canada ended up with a model that is far more conservative than its Supreme Court sought to impose. Interestingly, more litigation is going on in Canada now, seeking to challenge the conservative nature of the Canadian act, but the Canadian act is much more liberal, and we would say properly so, and it is workable. Canada is surely a most useful parallel for us to consider; it is by no means a harebrained scheme. It has been adopted. It is working and we suggest it is the best model to follow.

The next issue, quickly, is should assistance be provided by a doctor or perhaps a nurse—we just point to the fact that in Canada, interestingly, a nurse can provide the assistance—on the other hand, should it be a model, and I heard you ask Dr Syme about this, in which essentially the patient, or the person, administers the substance themselves? We would tend to agree with what Dr Syme said about it, that the default position perhaps should be that the person themselves, exercising their autonomy, does it, but there would be some exceptional cases where a doctor would need to step in. We would point out as well that in Canada, there is no prohibition on information about end-of-life choices coming from a range of people. Social workers, psychiatrists, nurses—all manner of people—are able to offer information. We would hate to see a situation in which appropriate people like those are prohibited from even discussing with patients and giving them information about their choices.

Then there is the interesting and difficult issue of the person who loses capacity at some point, particularly loses capacity, perhaps, after qualifying; that is, they have jumped the hurdles, they have been accepted, but they lose capacity for one reason or another and cannot, at the final hurdle, expressly indicate their further consent. We note that in Canada, that issue of capacity, including, I think, those who have lost capacity even before qualifying—the classic Alzheimer's cases—has been deferred for further consideration by the Canadian Parliament in December of this year. It is not a lost issue, but it is of importance. Victoria has implemented, as the committee would be well aware, quite new and detailed advance care directives under separate legislation, which on one view would appear to allow—there has been a recent article to this effect—perhaps the Alzheimer's patient to

provide an advance healthcare directive concerning assistance in dying at a particular point, and arguably that is now going to be the scheme operating in Victoria. We would suggest that that could be closely considered here.

The next issue, quickly, is soundness of mind. We would suggest, and I think we have said in the written submission, that we do not think that as a regular or inevitable step, a person should be required to see a psychologist or psychiatrist. Rather—again, I heard Dr Syme say something about it—the GP, the treating doctor, is well used to and has all the necessary expertise to determine capacity and consent, and if they have any doubt, they will undoubtedly refer to the appropriate type of specialist.

Then, finally, we just note the interesting and difficult questions arising from WA's size and disparate communities, Aboriginal communities in the north and other areas. In those ways, it is really very similar to Canada. We note that Canada gave some close and careful consideration to questions of distance and remoteness and difficulty in access to relevant medical care in remote regions. More than one person in this room is well aware of regional and remote complexities for people in this state. We just ask you to give consideration to that. On the ground, what difficulty will patients in remote areas have in getting access to the right people and qualifying? In the Northern Territory, when that act was operative, that was the major practical difficulty that was encountered. It is certainly, among other things, an argument for the involvement of nurse practitioners, as well as doctors. I am sure I have said more than enough. We just sought to highlight a few strands in a whole bunch of important issues and we would welcome any questions.

[3.00 pm]

The CHAIR: Thank you very much, Mr Hindle and Mr Walker. You have pretty much answered most of the questions that I had relating to this issue. The other part of this committee is also looking at advance health directives. I want to ask your opinion about whether your membership has advance healthcare directives and whether they are well utilised and understood across the community?

Mr HINDLE: We have our own living will, which has been around for a long time. It is only covered by common law, but I understand it is enforceable anyway, but we do encourage our new members to fill in the relevant forms—an advance healthcare directive and also the enduring power of guardianship—to make sure they have got all the bases covered. Interestingly, I had an inquiry this morning, and they were on the health department website and could not find access to the form. They found it ultimately after searching for about 20 minutes. This may be a reflection on the person who was looking, but I would have thought the advance healthcare directive is a very important feature of this particular problem, and perhaps they can be advised that it is not as easy to get the information as possible. I would have thought that if you went straight onto the website, there would be a drop-down on the top line, because whilst the advance health directive is not the most important thing in health, of course, it is something that people will be looking for. It needs to be more heavily promoted within the community and amongst the medical profession so that people are able to put in their wishes so that when the time comes and they go to hospital or whatever, the people who are looking after them can have access to that.

The CHAIR: Why does DWD promote living wills as opposed to advance health directives?

Mr HINDLE: I suppose it is something we have always had, and we tell people that if they want a braces-and-belt approach, then perhaps they can fill in the living will. But we would promote generally the advance health directive—the government document—as the main document.

The CHAIR: Is it the experience of your members that they are adhered to by the medical profession and easy to fill out?

Mr HINDLE: They are not that simple to fill out, but we have had no feedback that their wishes have not been carried out.

Hon ROBIN CHAPPLE: Just on that, can we get a copy of your living will?

Mr HINDLE: Indeed.

Hon ROBIN CHAPPLE: That would be very useful.

Mr WALKER: If I can just add something about that, I think it is Victoria, is it not, that now has two categories or classes of directives—a more conceptual one and a more practical and detailed one?

Hon Dr SALLY TALBOT: They just introduced it this week.

Mr WALKER: Yes, that is right. Thank you. I thought that might be something worth considering. I have sat down with at least one person, at their request, a couple of years ago, to draft an advance health directive for them, and we really talked around how specific it should be and how much you can try and predict what might happen in the future and list the various conditions and illnesses that could occur and what treatment or lack of treatment you would like. So I just wonder whether the Victorian development might be going in the right direction.

Hon Dr SALLY TALBOT: Some people have suggested there is a problem that ours is essentially blank. New South Wales does offer a lot of options.

Mr WALKER: Okay. I have not seen that, but I would tend to agree with that. I think still in the community the take-up rate is pretty low, is it not, even though government agencies have made efforts to publicise it? So, more effort is needed, and I think a more helpful form would be a good step.

Hon NICK GOIRAN: Mr Hindle, in your opening statement, you referred to a presentation that you gave, I think, recently and to a question that you posed to the audience and asked them to put their hand up. What was that question that you asked the audience?

Mr HINDLE: I just bumbled though that a little bit. I have actually got a typo here—that is why I stumbled. I asked them how many of them believed it was their right to have an end-of-life choice. That was a pretty basic, simple sort of question. The latest Morgan poll that came out in November of last year was much more specific in the questions that they asked. You would all be familiar with this, presumably.

The state-by-state analysis was and the question was: should a doctor be allowed to give a patient a lethal dose? There is no ambiguity there. It probably needs a bit of amplification. But, anyway, in Western Australia 88 per cent of the respondents to this particular survey said they thought it was, and through the country it was an average of about 85 per cent. We would maintain that there is obviously a need for some form of assistance, whether it is a lethal dose. I would have thought that probably, as my colleague suggested and I heard Rodney Syme say, a drug that the individual can get after meeting the criteria and then take it themselves is by far the best option. It then takes away “the doctor’s a killer” sort of attitude that seems to be rife, and the person is able to do it themselves. Even if a doctor does help, he is really only facilitating the person to take their own life. I suppose it depends on how you look at it, but giving an assistance, handing a person the drug or at least giving it to them because they cannot handle it themselves, I really do not see that as killing them.

Mr J.E. McGRATH: Is there much evidence of things going wrong? When someone has been given the prescription, got the medication, gone home, decided the time was right and attempted to take it and something goes wrong, is there any evidence of that happening?

Mr HINDLE: Not to my knowledge. Has Philip Nitschke been before the committee? Has he appeared? Yes. Philip is a great believer in the wonder drug Nembutal, and I think Rodney mentioned briefly that if we end up with a cocktail, you could have problems. But there is no doubt that Nembutal is the gold standard. You take a swig of that—100 millilitres of water and seven grams of Nembutal powder and you drink it down—and within a minute you are asleep and within 20 minutes you are dead. I would have thought that because it is a medical issue, the method of delivery and the substance will be decided probably outside the legislation. But Nembutal is the way to go. I am not aware of anybody who has taken Nembutal who has not succeeded in what they set out to do.

Mr WALKER: Can I just point out something in that regard? One of these articles we provided today, interestingly, does refer to that. It is the one about Oregon's act and 20 years of experience, written by Hedberg and New, who, I am sure, have letters after their names certainly, and I think they work for the relevant agency in Oregon so they are not partisan about it. They say that —

Mr J.E. McGRATH: Page 2, is it?

[3.10 pm]

Mr WALKER: The second page, yes. Under the heading “DWDA Process”, halfway through there —
Health care providers were present at the time of death for 42% of patients: 80% during the first decade ... and 30% during the second ...

That is interesting, too. Then they say —

Overall, 5% of patients lived more than 6 months after their prescription was written.

Then —

Seven patients (0.6%)—regained consciousness after ingesting the DWDA medications; 6 of them died of their underlying illness (1 patient is still alive).

So there have been instances of people waking up, and one only—I think it is elaborated on later in the article—had some problems associated with it. Sorry; there is another paragraph and I had seen it. But, overall, any incidence of that sort of thing is very low indeed.

Hon NICK GOIRAN: So, Mr Walker, you are saying, then, that what Mr Hindle has just said to the committee—that he is not aware of anyone who took Nembutal but did not succeed—is not correct, according to that article. Is that right?

Mr WALKER: According to this article —

Mr HINDLE: They may not have used that drug, of course.

Mr WALKER: Yes.

Hon NICK GOIRAN: And this is Oregon?

Mr WALKER: It is. If you look at page 4 of the same article on the left-hand side, in Oregon—I think, from memory, this is unlike Canada—the second sentence in that paragraph —

It does not include requirements for who is to be present when medication is ingested —

And so on. No, that is not the point. Just above that actually, halfway down on the left-hand side —

Over 20 years, 7 patients regained consciousness after ingestion. Patients and families might benefit from the support of health care professionals being present throughout the process.

In Canada, I think the view was taken that the doctor—in fact the law says, I think—has to remain present, in brackets, in case there are any problems, but in Oregon the model is the prescription is

there, the patient deals with it themselves, and problems have been very few and far between. These articles are very helpful, I think, in understanding how the different processes work. Nothing is perfect, but these articles are highly reassuring, I would suggest, in describing how it happens in Oregon.

The CHAIR: Do you have any further questions on that?

Hon NICK GOIRAN: Not on that theme.

The CHAIR: Do you have any of your members that you are aware of who have committed suicide after a diagnosis of terminal or chronic illness?

Mr HINDLE: Yes.

The CHAIR: Over the years. Are you able to quantify that in any way?

Mr HINDLE: The number? I know of three, but then they were members of Exit, so they were able to avail themselves of Dr Nitschke's magic powder. Therein lies one of the problems, that people are actually breaking the law—I do not know to what extent now, but there was a supply coming through from China—by importing it. They are class A drugs, I think, are they not? Yes. You have a problem with people breaking the law to do what they should have a right to anyway, and obviously there are people who are breaking the law who probably would not qualify under any legislation that we would have who have other conditions that make them commit suicide. On the other hand, you have a situation within the medical profession where some doctors are easing the burden, and some say, "Well, I've never done it and I never would." But we know for a fact—everybody knows—that people are helped. A friend of mine died just recently and he had terminal cancer. He went in on a Wednesday, he had been not well but he was declining rapidly, and on the Saturday night he died, but he was given terminal sedation. Now, we do not think there is any real difference between giving people terminal sedation and being a bit cute about saying, "We're only trying to relieve their pain and their symptoms", because they know that ultimately this person is going to die. So why would you prolong the agony, if you like? By the time we got to see him, he was having his mouth kept dry and he was basically in a coma. I do not know how upsetting that was for him, because no-one has ever come back out of one of those situations and said, "I was feeling stressed. I was uncomfortable"—whatever. Usually they die and that is it.

Mr J.E. McGRATH: Further to that question, what we hear from some people is it is sometimes more distressing to the family, the people who are visiting. Maybe your friend was not feeling any pain or —

Mr HINDLE: No; that is right. The family, in his particular situation, was not so bad, but I had another friend—I might be jinxed!—whose wife had pancreatic cancer and she took 18 months to die. My friend said, "It was the most horrifying experience of our life"—what she went through, a loved one, to see it happen. She wanted to live. They would have had to go through it anyway, but if she had had the option, as Rodney Syme said, the family can be there. It is commonsense.

Hon COLIN HOLT: Further to the chair's question around your membership, it seems to me the challenge is that it is not illegal to commit suicide, but it is illegal to import a substance to actually assist you, but it is also illegal to assist a suicide.

Mr HINDLE: It is, yes.

Hon COLIN HOLT: You know of three members who imported a substance illegally to assist them. What about in another circumstance where you know that someone of your membership has committed suicide, they have not imported illegally —

Mr HINDLE: They have used other means?

Hon COLIN HOLT: Yes.

Mr HINDLE: I am not familiar—I do not know whether you are, Steve—whether there is anybody else who has done it? The members that we know, probably, yes, there are three or four, or maybe even more when I think about it, but they are people in an advanced stage of their life. There is evidence of course, and you have probably heard of the terrible way people have killed themselves when they have been in that sort of situation—nail guns and hanging. Hanging is the preferred method, or it seems to be the most common. I would say “preferred”. It is the most commonly used method that old people use to commit suicide. It is pretty terrible for those around them. I suppose even with legislation, there are still going to be suicides.

Mr J.E. McGRATH: Further to that question, of your 680 members, when you talk to some of these people and they want to talk about the end of life and how they want that choice, do some mention they would rather someone be there or their doctor be there, or do some people say, “I’ll just go and do it on my own”? People have very close relationships with their GPs; they have maybe looked after them for 30 to 40 years or more; or maybe family members they want to say, “I want to pick the time and get the family in and then end my life.”

Mr HINDLE: I think that the majority of them, and there have been studies done, most people want to die at home. Very few actually do. But they want to die at home with their family around them. The family cannot sit around for three weeks waiting for them to die. That is why if they had the choice. As Rodney Syme said, nobody wants to die, but you get to a point in life where it is unbearable and it does not matter how much love and care and prayers you have had said for you, you have had enough. Enough is enough. That is when these people hang themselves. That is when they use a nail gun on themselves. Anything would be better than what we have now.

Mr WALKER: Can I add something to that as well, please? Certainly, I am aware of quite a number of people, in discussion, who have said that—thinking of some of those who subsequently did take their own lives, and the ones I have in mind all did it alone. They did that really for one reason, and that is to avoid any risk of friends and relatives being charged with assisting in the suicide. I think it is a great concern to those who do end their own lives that they have to do it alone. They consider they have to do it secretly, that they cannot tell anyone at least clearly what they are going to do and when they are going to do it. They drop hints and they do it alone. I think the great majority of those would certainly have preferred to do it with saying goodbye first and, secondly, to have people around them of their choosing, yes. But the question was aimed at what do our members tell us. Frankly, whenever we have general meetings and they come along, including in their gophers, the median age of membership, I do not know what it is, but it is not low! What they want to say is, “Why don’t the politicians change the law?” and they want to see it done. That is what they tell us more than anything else, I have to tell you.

[3.20 pm]

Mr HINDLE: We had a real character as a member—Trudy Thompson her name was. She was a Jewish lady. She would say, “Why don’t they get off their arses and do something about it?” Every time she came to a meeting, she would sort of wave her flag. She came in in a gopher, too. She was a very intelligent woman. I do not know what she —

Hon ROBIN CHAPPLE: She was a nuclear physicist.

Mr HINDLE: Yes, a nuclear physicist.

Mr WALKER: And she would delight in saying how in Berlin in 1938, she deceived the Gestapo officers who came to the door to locate and arrest her father. The family managed to flee to England

before they were imprisoned. She would say, “I’ve dealt with the Gestapo; I can deal with these people!” I am not suggesting anything inflammatory or in contempt of Parliament here.

Mr HINDLE: Sadly, she is gone, but she was one who helped herself.

Hon Dr SALLY TALBOT: It is striking that on the list of underlying illnesses, we do not have dementia. Can you foresee any system of voluntary assisted dying that would include people with dementia?

Mr HINDLE: I do not think in the short term. I think that probably we will become a little more sophisticated with our advance health directives and that sort of thing. Maybe there will be a provision that a person can do an advance healthcare directive and say that if, in the event—because dementia is the greatest problem we are going to have in the future —

Hon Dr SALLY TALBOT: Do your members raise that as a reason for joining the organisation?

Mr HINDLE: Not necessarily. I think they would all like to have the opportunity if they became demented. But I do not think that they see that as a reality. I think they think that is probably a bridge too far. Who knows? It is a terrible disease. It is a condition so —

Mr WALKER: Sorry; can I add something again?

Mr HINDLE: Yes.

Mr WALKER: Many people raise it as a great concern and it seems to be one of those pressures that leads some people, I think, to take their lives sooner than otherwise they would have. They fear that they will lose capacity—we have not got a law yet, I know—they cannot communicate their wishes at the time when ideally they would want to, when they are in a certain kind of condition. I really have felt that some people have probably taken their lives sooner than they wanted to ideally because of the fear of dementia coming on.

Hon NICK GOIRAN: I am interested in this topic of what I refer to as elderly suicide. I note that on page 14 of your submission, you refer to some statistics that I think in fact it was Mr Denton had obtained from the National Coronial Information System. You state that on average two octogenarians a week are killing themselves in this country and the most common method used is hanging. The committee has received evidence, and I do not expect you to necessarily be familiar with it because there have been more than 650 submissions, but submission 391 is from a group known as the Royal Australian and New Zealand College of Psychiatrists. What they say in response to this issue is that the high rate of suicide in people aged 80 and above “has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness, whereas the aetiology of suicide is complex and usually multifactorial”. Would you agree with the college? I should hasten to say, in fairness, that I am referring to a submission that you may well not have seen, and if you would prefer to take it on notice, that is absolutely no problem.

Mr WALKER: No, we have not seen it, but I would like to comment if I may. With respect, it is difficult, is it not, to come up with a two-line summary, black and white, that categorises something like this, but I have read Dr Syme in the past and I think I heard him telling you today about the nature of suffering. He speaks in his books about existential and psychological suffering. That kind of suffering is just as intense and difficult as pure physical suffering. I did want to mention as well that if you have time to read Justice Smith’s judgement—it is a lengthy judgement, but it is very readable—I think it is absolutely terrific. It was Justice Smith in the Supreme Court of British Columbia in the original trial that went on to the Supreme Court—Carter v Canada. She had all of the experts in front of her on both sides of the debate dealing at length with Oregon, Washington, Belgium, the Netherlands and some other places. She came up with some very well considered views, teasing all this out about the risk of suicide contagion, as it is called, and the nature of

suffering. I think that with elderly suicide, like those who have chosen a legal end of life under those various schemes, those people are beset by a range of factors that inform their suffering. Some of it is physical, some of it is existential. It is concern about the future. It is concern about pain in the future and the nature of the death that awaits them. I am not sure that it is easy to categorise it. I would really just commend what Justice Smith has written, because it presents a holistic sort of approach to this and I think gives you a good understanding of it.

Hon NICK GOIRAN: Mr Walker, you are a barrister in this state and you will appreciate that this committee needs to weigh evidence. Is your submission to the committee, then, that we should be attributing a lot of weight to the decision in *Carter v Canada*?

Mr WALKER: Yes, along with all of the other materials we have referred to. She had the advantage of all of these witnesses and they were cross-examined and tested. You will see when you read her judgement that by no means does she just easily come down on one side or the other. She finds fault with this argument and that argument. She has reason to express concern about certain things. But in the end she very clearly comes down on the side of saying that the systems that she has looked at and heard about operate well and that there is virtually no abuse, that there is no coercion or imposition upon elderly people or people who are otherwise vulnerable, that safeguards can and do work, and that, as I would read her, nothing is perfect and we need to maintain vigilance. However, overall, despite the myths that go around, she found that the systems in these various jurisdictions do work very well.

Hon NICK GOIRAN: So, should greater weight be given to the decision in the *Carter* case or to the Royal Australian and New Zealand College of Psychiatrists?

Mr WALKER: I have not read their submission, but I know for one thing that they did suggest that, in every case, a patient to receive end-of-life assistance should be seen by a psychiatrist. I heard the psychiatrist sitting with Dr Lugg here, and Dr Lugg himself, express different views. I do not know why the college of psychiatrists might have said that, but I think that Justice Smith had much more evidence, and contested and fought-out evidence, in front of her than the college ever had. I have known a lot of psychiatrists, because I was on the Mental Health Review Board here when it was first created. I am not anti-psychiatrist—there are a lot of lovely people there. But I do not know that any simple view of that kind could be maintained in the face of all the evidence.

Hon NICK GOIRAN: With that experience in mind, have you come across situations in which two psychiatrists might differ?

Mr WALKER: Yes, absolutely.

Hon COLIN HOLT: Just quickly, you said earlier that it seems that the six-month limitation period in Oregon came about because of health insurance requirements.

Mr WALKER: Yes.

Hon COLIN HOLT: Could any similar sorts of situations occur in Western Australian or Australian jurisdictions that you are aware of?

Mr WALKER: No. I am 90 per cent sure that the reference I found to that was in the Victorian report. I could dig it out for you if you like. Wherever I read it, the observation was made that this is an issue that arises in America. I am not sure about Canada. It does not arise in Australia, because there is no linkage; there is no reason to think of it that way at all. We have a universal healthcare system.

The CHAIR: Thank you very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. Any such corrections must be made and the transcript returned within 10 working days from the date of the email

attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. Thank you very much, Mr Hindle and Mr Walker, for your evidence.

Hearing concluded at 3.32 pm
