

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, 9 MARCH 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 1.48 pm**PROFESSOR DOUGLAS THORNLEY BRIDGE**

Senior Palliative Care Specialist, UWA Faculty of Medicine and Health Sciences; WA Country Health Service; Royal Perth Hospital, examined:

The CHAIR: Welcome, Professor Bridge. On behalf of the committee I want to thank you for taking the time to speak to us today and agreeing to appear today to provide evidence to the end-of-life choices inquiry. My name is Amber-Jade Sanderson and I am the Chair of the joint select committee. We have Hon Dr Sally Talbot; Mr John McGrath; Dr Jeannine Purdy; Hon Colin Holt; Hon Nick Goiran; Mr Reece Whitby; and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you may say outside 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 website following the hearing.

Before we begin, do you have any questions about your appearance today?

Prof. BRIDGE: No.

The CHAIR: I understand you have a presentation for us, so I will let you start with the presentation if that is okay and we will then go to questions. I ask members to perhaps hold questions until the end. Over to you, Professor.

Prof. BRIDGE: How do I change the slide?

The CHAIR: Just indicate to the staff and they will click it for you.

Prof. BRIDGE: I would like to introduce my talk by a quotation from Atul Gawande; some of you may have heard him speak in Perth a year or two ago. He is a very prominent physician in North America and an adviser to the previous President. This is what he says —

“For most of human history, death was a common, ever-present possibility. But now, as medical advances push the boundaries of survival further each year, we have become increasingly detached from the reality of being mortal.”

“Medicine's focus is narrow. Medical professionals concentrate on *repair of health, not sustenance of the soul*. For more than half a century now, we have treated the trials of sickness, ageing, and mortality as medical concerns. It's been an experiment in social engineering, putting our fates in the hands of people valued more for their *technical prowess* than for their *understanding of human needs*.

That experiment has failed.”

That is fairly damning commentary from a leading academic in North America.

This is my own statement —

- Medical school education emphasises curing diseases, using technology and pharmacology.

- When both the doctor and the patient avoid the reality of death, the result can be a prolonged, distressing, agitated, fearful, lonely death, on a hospital bed, entangled in tubes, instead of in the embrace of a loving family.
- In other words, the patient receives expensive, futile treatment which **increases** suffering.

I am awfully sad to say that that can happen in Western Australia, and does, too often.

I would like you to ponder this slide, which I took some years ago, on the tenth floor of Royal Perth Hospital in the bone marrow transplant unit. In the bed is a 21-year-old lad dying of leukaemia. I was asked to see him because he was in awful pain. As soon as I stepped into the room, I felt a terrible sense of distress and wrongness; this was not right. This boy is dying; he should be at home with family around him. Instead, he has six intravenous pumps. They always beep in the night, they squeak, they break down. The nurse said, "You should have come yesterday; he had nine pumps yesterday." There is only one redeeming feature in that room: a CD player, playing music. In fact, when I walked in at that moment, it was playing *Amazing Grace*. Quite a poignant song in that context. He died a couple of days later.

This is the best medical technology we have to offer, and I am not knocking it; we are blessed by fabulous technology, but it is not always used appropriately. When the doctor is afraid to say stop and the patient is afraid to say stop, there is a kind of conspiracy of silence where it just goes on and on and on.

I did a locum a year ago at Fiona Stanley Hospital and that was the one thing that stood out to me: awfully sick patients dying and wonderful, compassionate physicians standing there, unable to say, "He's dying", unable to say, "Let's stop." It's just too unpleasant, so we go on and on. We have to escape this. Is there an alternative?

When I show this next image to medical students, I ask, "What do you see different in this picture?" They say, quite rightly, that the man is an old man; that is quite different. But the main difference is that he is at home. He is in his lounge room, with a hospital bed lent by Silver Chain, with oxygen lent by Silver Chain and his old wife sitting on a chair next to him. I know that scene very, very well because that was my father. He was 92 and he died at home, totally at peace. That is my ideal—that everybody should die at home, in peace.

In my submission to the committee I gave some documents a few months ago—I do not know if you got those? That photo is on the front cover.

The CHAIR: Yes, we did.

Prof. BRIDGE: I called it "Dying Healed", quoting my favourite mentor from North America, the Canadian surgeon who invented the term "palliative care", Professor Balfour Mount. He said it is possible to die healed. When I first read that I thought, "That's a misprint. How can you die if you're healed?" But he is distinguishing the difference between being cured. He says that the cure does not matter; it is about personal maturity, peace, harmony, and it is possible to die healed.

Now I have revealed the secret; this is my father's death. He was in Fremantle Hospital and on a Sunday afternoon he said, "Doug, I want to go home", so I said, "Right, I'll take you home. I'll shift into your bed, I'll get some support. I think you've got about a week to go. You've got three leaking heart valves, your kidneys are failing, I don't think you'll pull through this time." My father was a very distinguished Perth citizen, the founder of Jayson Industries, a distinguished businessman and at 92 he was still living alone, driving his car, but he was ready to die. So in that week, every grandchild, great-grandchild and relative came to say goodbye. To me, that is what death is about—it is a family social event, not a medical event.

For 20 years I was head of department at Royal Perth Hospital. I tired of coming to a patient and thinking the same thing every time: “They’ve called me to see this man; he’s dying. Going to surgery tomorrow is not going to help him. Another MRI scan is not going to help him. Taking his blood pressure every four hours is not helpful.” So I came up with this very simple statement. I wrote in the patient’s name, “George is dying”. My colleague said to me, “That’s a bit abrupt, isn’t it? Can’t we say ‘deteriorating’?” I said, “No, that’s the whole point—he’s dying.” The goal of care is comfort, dignity and family support, not prolonging the dying process. So I put down “considerations”—not “instructions”, not “compulsory”—things that we might like to think of now that we agree the patient is dying. Does the patient actually know if they are still conscious? Has the family been told, “Your dad is dying”? Strangely enough, and sadly, very often they have not. Once we have agreed, yes, he is dying, a few days to go, “Where would you like your dad to die—here? At home? In a hospice?”

Years ago staff used to say, “He’s too sick to go home.” I would say, “He’s so sick that he must go home, especially if he is Aboriginal. Going home to die in country is absolutely essential.”

The third item says, “Cease unnecessary observations, medications and investigations”; not “stop everything”, not “do nothing”, but be selective and think, “This won’t help, this won’t help, this won’t help”, so life becomes very simple and focused on family.

Number four: “Remove unnecessary tubes and devices”.

Number five is the controversial one: “Cease artificial nutrition and hydration”. That means, stop pouring in fluids intravenously, stop trying to force-feed, stop feeding via tubes. Some families have great trouble with that, especially people of Chinese origin, for example, who feel you must always press on and give nutrition. “To die means you have a drip in your arm, doesn’t it?” “Why?” “We always do.” “Why?” “It must be doing something good.” It is not.

Number six: “Prevent pain, dyspnoea, nausea, secretions and agitation”. Prevent every distress, but those are the big ones. Start off with pain, which is usually not hard to treat. Dyspnoea means breathlessness. Nausea, secretions and agitation.

[2.00 pm]

A very simple thing that is often overlooked is to give good mouth care. A person dying does not say, “I’m hungry.” They might say, “I’m thirsty” but what they really mean is, “My mouth is dry”. To wet their mouth with a swab or a spoonful of water is beneficial and helpful. It makes the family feel useful and I suppose it does no harm.

“Give regular turning and a comfortable mattress”. Some of you have been on a Qantas flight interstate all night sitting up in economy class. It is horrible. We should not make families grieving the imminent death of their partner sit up all night in a chair. It is criminal. I say to the hospital staff, “Haven’t we got a decent bed somewhere? Get it.” If two people want to stay, or if an Aboriginal family want five people to stay, let us do it. What about occupational health and safety? Be blowed; I am a bit of a stirrer. Dying is a profound, special, unique event and we should not let regulations get in the way.

Number nine: “Offer support from pastoral care”. Ask, “Are you the kind of family who would like to speak to a priest or a rabbi? No. Is there anyone you’d like to talk to? We can arrange that.”

MET calls; that is, to the medical emergency team. In a healthy ward, if a patient’s blood pressure drops, the button is pressed and the specialists come rushing to fix the problem. Cardiopulmonary resuscitation is not appropriate. I am not against CPR; in fact, I hold the world record, I think. Thirty years ago I had a patient in ICU who died 100 times. His heart stopped beating. It was so simple. In the end, he would be reading a paper and he would go, “Nurse!” and the nurse would press the

button and he would go “Oh!”. Then he would say thank you, and go on reading again. That is what cardiopulmonary resuscitation is for; a well patient with a temporary problem who is going to get better. The patients I see are not like that and CPR is ghastly, breaking ribs—horrible stuff.

The Royal Australasian College of Physicians’ Chapter of Palliative Medicine realised that spirituality, however expressed, is a key dimension of the human experience and spiritual issues impact on suffering. Spirituality is a difficult word. It may not be the perfect word. It is not religion. It is not ethics. It is about the spirit of a person. I have been in the college for 20 years on the committees saying, “What are we doing to teach this?” The answer is nothing. Is it important? Very important. How can we say it is important, but not teach it and not assess it? What are we going to do? Over a period of 15 years, I have evolved a training workshop, which has become popular and accepted. It is just about to be adopted by the college for general consumption. Last weekend, I spent the weekend at a lovely country retreat in a place called Tocal, inland from Newcastle. There were 70 doctors and nurses and chaplains meeting over two days to explore the spiritual dimension. It was a wonderful, healing, profound experience. They all said, “Let’s do it some more! Come again!” I cannot come again very often. I am getting too old and frail, but I am hoping to train 10 others to take over to facilitate the workshops to explore what spirituality means.

I would just like to give you a couple of minutes on the wheatbelt. My main job now is a consultant to the wheatbelt and the midwest—two regions of Western Australia. The wheatbelt is slightly bigger than England. It has 24 hospitals, eight nursing posts and 38 aged-care facilities. Who staffs that? There is one nurse manager, one part-time clinical nurse, one part-time social worker, one part-time admin and my kind manager said “a very dedicated palliative care medical specialist”—that is me—one day a month. I asked him to tell me how it was going and he gave me this rather sad story.

A terminal patient—I do not quite like that word, but a man or a woman who is about to die—presented to the Southern Cross Hospital after hours. The patient was seen by emergency telehealth—that is by videoconferencing. The decision was made to admit the patient, but there was no doctor with admitting rights, so the patient was transferred to Merredin 109 kilometres away. Merredin had no admitting doctors so the patient was sent to Northam, 270 km from home. Northam had no beds, so the patient was transferred to Perth. The patient died alone in the ED in Perth 360 kilometres from home. Bad luck; tough; it cannot be helped—really? Can we not do better than that? It is not fancy philosophy or magic planning; it is very simple.

A terminal patient from Beverley presented to Beverley Hospital ED after hours. There was no doctor available with admitting rights so the ETS, the emergency telehealth service, in the ED arranged for the patient to be transferred to Armadale. The patient died in the ambulance.

You might say, “This is tough stuff. We can’t always get it right. It is easy in retrospect”, but we should be able to plan for this. This is going to happen every day, all the time.

I have been reading with interest the transcripts of the inquiries you have had over the last month or two—amazing stuff. Morphine, morphine, morphine keeps coming up with misunderstandings, so I thought I would give you my small take on it. The sort of statement I hear is, “My father was secretly euthanised. The nurse gave him an injection of morphine and he died three hours later.” The second statement may be true, but I doubt the first is true. When I started doing this in 1983, there were no textbooks, no courses, no qualifications, no-one to turn to. Silver Chain said to me, “We’re about to start home care in Claremont. Occasionally, we will have a difficult patient we can’t look after. You’re a nice, kind physician in Fremantle Hospital. Would you take them in and look after them?” I naively said, “Yes, I’ll give it a go.” Shortly afterwards, my intern rang me on Saturday morning, “Doug, I can’t stop this guy’s pain. What should I do?” I said, “Give him some morphine.”

He said, “I have” so I said I would be there in five minutes. I came into the room, saw the ampoule and said, “What’s this, David?” It was morphine sulphate, 30 milligrams. That is a big dose. I asked what he had done with it, and he said he had given it intravenously. I said, “Uh-oh, that could be fatal. What’s all this?” He had given him 20 ampoules of 30 milligrams in the last hour and he still wanted pain control. If you did not trust me, you would say this is rubbish; that is enough to kill an elephant. How could he give a man a massive, massive, massive overdose, intravenously? Highly dangerous! I had no idea. I was despairing. Now there is lots of research and knowledge and I would say, “This is easy, David; stop the morphine. He has opioid-induced hyperalgesia syndrome. The morphine backfires in the cell and makes it worse. Stop the morphine and give him methadone and ketamine. He’ll be right in a few hours.” In the last 35 years since I did that, we have had huge advances in pain control. I have been privileged to be involved in methadone research and I believe it is a fabulous drug, but it is tricky to use. It can be dangerous.

There is hardly anything more confusing than the food and fluids stuff. The terminology is where we start to go wrong. A person who is not eating or drinking is variously called “fasting”, which is what you do before an operation, or for spiritual meditation. “Voluntary refusal of food and fluids” means you might deliberately want to die. A “hunger strike” can be for political gain in Ireland for example. “Starving to death” has different, horrible connotations. “Dying of thirst” sounds ghastly. And “palliative starvation” I had never heard of until I read it in one of the transcripts. So, what are we talking about? This is so difficult that I wrote a brochure. I am happy to give you a copy. It was written about 20 years ago. I called it “Is he hungry or thirsty?”

The question I pose is that when a person is close to death—a few days or weeks—questions about food and drink can cause a lot of worry for families. Providing food is one of the ways we show our love and concern. Everyone knows that if you stop eating you will feel weak, lose weight and die. I then quote some illustrative examples.

[2.10 pm]

I first was interested in this in 1987, when six shipwrecked sailors from the *Singa Sea* were airlifted to Fremantle Hospital. They had been at sea for 29 days, with one cup of water per day each. I could not believe that. A kidney specialist said that that was impossible. I said, “Dan, it might be impossible, but where do they cheat? They couldn’t go to the fridge in their lifeboat. There’s something funny going on here.” I discovered the physiology of fasting. Bears hibernate for six months. Humans can hibernate, sort of, a little bit. There are special mechanisms in the body, when you stop eating and drinking, that allow you to live for weeks and weeks, if you are healthy. The question for us today is: what happens if you forcibly stop a patient from eating or drinking, or what if they voluntarily say, “I just want to die; I’m not going to eat and drink anymore”? That is really what Christian Rossiter said, and you have heard him quoted many times. He said, “I’ve had enough; stop feeding me; let me die.” At the time I thought that was straightforward; he can do that. But the doctor in charge decided to test it in court and it went on for weeks and weeks. I got tired of reading newspaper letters saying that the poor fellow would have a terrible, horrible death. So I rang up the editor of *The West Australian* and said, “This is just rubbish.” He said, “Well write me an article in 36 hours, and I will publish it.” So I wrote an article, which was published. It is very similar to what I put in this brochure, which basically said that when a person stops eating and drinking their body changes its metabolism. After the first day or so they get used to it, and they actually enter into a peaceful state, where the ketones and other chemicals from fasting allow the mind to be clear and relaxed. It is not a horrible death, despite what Andrew Denton might tell you. I wrote to Andrew Denton last year and said, “Andrew you are promoting this idea of a horrible, suffering, starving death. It is wrong. Please can I talk to you?” I sent two articles to explain it, and he did not reply.

When physician-assisted suicide was legalised in Oregon about 20 years ago, the local people were concerned to know how it would work out. Professor Linda Ganzini wrote to all the hospitals in Oregon and said, “What’s your experience of people with physician-assisted suicide and, by the way, have you had anybody just stop eating and drinking?” The results were astonishing. They were published in the *New England Journal of Medicine*—the most distinguished journal in the world—and the editorial said that this is unbelievable. What did she find? She found 102 reports of patients who had voluntarily stopped eating and drinking until they died, and she found 55 patients who had used the physician-assisted suicide legislation and died. The nurses watching the deaths rated the fasting ones as more peaceful and more comfortable than the suicide ones. That is what Professor Ganzini found unbelievable. She kept reading the data and thinking that it could not be true, right until she published it. That is a very important statement from a major medical journal.

The Dutch are way ahead of us in euthanasia experience. I paid more than \$100 for a Dutch book on euthanasia to find out their view and, lo and behold, there is a chapter called “Voluntary refusal of food and fluids”. It turns out that it is very common; it is a standard way of dying in the Netherlands. The old couple will say, “We’ve had enough now; we’ll just stop eating and drinking.” They do not consult a doctor or lawyer. They do not need permission. It is not illegal. They just quietly fade away after a week or so. Professor Chabot wrote about this and said he was surprised. He estimated that thousands of people in Holland fast until they die. That may be new to the committee. It is unexpected and counterintuitive, and to me it has major implications. Rodney Syme, the Victorian surgeon who is very pro-euthanasia wrote in his book that he was surprised to find that this is the way that it happens, and it is quite positive and helpful, but he said that it is too slow. We are impatient, and we want to get on with life, or death. We cannot wait a few days. He was saying it is legal, it is peaceful, and it is okay, but the only criticism was that it is not quick enough.

Next slide, please. I read this with some sadness. Andrew Denton spent some days at the Sacred Heart Hospice in Sydney, perhaps the leading centre for palliative care, under the guidance of Professor Richard Chye, an outstanding physician. Andrew said the most shocking thing he learned was that it is okay to refuse food and treatment until they die: “Seared into my brain is the conversation”. This is excellent journalism, but it is wrong science—“Psychologically painful for the patient and the person dying.” I had dinner with Richard Chye last year and asked him about this. He said the patient they were discussing was actually brain-dead. There was no possibility they were thirsty or distressed. It was part of the dying process that they stopped giving artificial food and nutrition. So I guess my caution to the committee is, be cautious about accepting medical evidence from Andrew Denton. He is a fantastic journalist, but I think his medical science is deficient—my personal view.

Next, what happens if you have standard food and drink when you do not need to? I am sad to say that this slide was taken in Royal Perth Hospital. The kind, loving staff gave this patient nutrition. She was dying and unconscious, and unable to swallow, so they used this thing called a Kanga pump. She got the right treatment—two or three litres of nutritious, milky fluid every day. I now want to show you a rather sad slide or two. She was blown up like a balloon. I would say she had at least 20 kilograms of excess water, which was just pouring in and not coming out. That is not healthy nutrition; that is ugly, painful and destructive. I have got two more slides, which you can see. Medical students are taught to test for pitting oedema, which means you press on the leg for a few seconds, take your thumb away, and it leaves a hole. It shows how much that leg is waterlogged. The next picture is rather ugly. It is not for publication. This is gross indignity. This poor lady is blown up with fluid—ugly, she does not like it; she tried to pull it out, so she was put in mittens, so she cannot even look after herself. How can we do that in—probably 2010, that was. We are still doing this. We start off saying that the patient must have food and drink, which is true, or they might die, which is true,

but we have to say, maybe that is all right. Are we trying to make them die slowly or not? Are we trying to prolong their death or, even worse, are we trying to cure them? If we have the right diagnosis, the patient is dying. Let them die, peacefully.

The next slide touches on a rather difficult one, which is turning off the ventilator. I am not talking about ICU, where the patient is dead and they turn off the machine. I am talking about palliative care, where the patient is fully alert and apparently healthy, but they are kept alive artificially by non-invasive ventilation; that is, a mask on their face. It breathes for them, and if they take it off they cannot breathe. If they have it on, they breathe. It is a great measure to support the patient, and keep them alive for months, but what if they have got motor neurone disease and they come to the end of life and say, "I don't like this anymore; I want to stop"?

[2.20 pm]

That first happened to me 20 years ago. The patient said, "I want you to sedate me. Take the mask off. Let me die." I said, "I can't do that. I'm a doctor. I'm a healer." She said, "Am I not allowed to stop this stupid treatment?" I said, "Yes, you can, but I'll be uncomfortable. Okay, compromise. I'll sit next to you, take the mask off, and if you feel distressed, I'll give you some tranquilliser." She said, "No; no way. I know I'll be distressed straightaway." I rang the consultant physician in charge of her—a lung specialist—and he said, "Oh, that's pretty drastic stuff. I'd better come and talk to her." He did not come until 6.00 pm. He rang me at home at 7.00 pm and said, "She wants to do it. What should I put in her syringe driver?" I felt uncomfortable. I did not want to be involved in this. I could not sleep that night. The next morning, she was still awake. She said, "Can't you do it some more and put me to sleep?" So she was sedated and the mask taken off. That is the most unpleasant thing I have ever done—sedating a patient, taking off their mask, and letting them die. My head says, "You have withdrawn futile treatment, at the request of the patient—you and she, or he—knowing that the patient was going to die. This is ethical, compassionate and legal." My heart responds, "You just killed that patient." There is an emotional response which is very unpleasant, and a cognitive intellectual response which says, "This is fine."

The next slide is a true example. I have written signed permission to show this photo. This man was about 70. He had advanced lung cancer. He was dying. He was kept alive by a breathing machine for some days. He said one day, "I've had enough. Just turn me off." I spoke to him at some length. I spoke to his family. We had long conversations. We agreed it was okay. So in the morning, peacefully, with the family present, he was given extra sedation, he was relaxed and unconscious, the mask was taken off, and he died peacefully a few minutes later. Does anyone have a problem with that? Depending on your world view, your belief system, your religion, you may say, "This is murder, suicide." I find it very distressing, but legal and ethical. I do not think we need to change the law to allow it to happen. We need to educate doctors and nurses that it is okay. That is my view.

I wrote to my friend Dr Balfour Mount a few months ago and said, "Canada has had euthanasia for one year. There is an international report. What do you reckon about it?" He wrote back one particular comment, "I am disturbed by the acronym MAiD, medical assistance in dying. Misleading! Dishonest! How strange! I was under the impression that medical aid in dying was what I had been doing for over half a century. It was a clever and devious choice of an acronym, with its subtle suggestion of a caring maiden."

The terminology we are using is quite complex. There are surveys purporting to show that people want this. It depends what you ask them. If you ask them do they want medical assistance in dying, they will say of course. I have been doing that for 35 years, with 30 000 patients, and I struggle with

the idea of deliberately ending their life. I may have gone over time. Forgive me, Madam Chair. I am open for questions.

The CHAIR: Thank you, professor. We have heard evidence, and you obviously have extensive experience in palliative care, possibly more than most in Western Australia, or even Australia, that a peaceful death under palliative care is possible for anywhere between 98 and 100 per cent—sorry; let me put that another way—that it is not peaceful for anywhere between one and five per cent of patients. What are the options for those people? Is that where you would resort to what you call palliative sedation?

Prof. BRIDGE: I have been following the evidence at the hearings and the transcripts, and this seems to come up all the time. I have trouble getting my head around the question. I do think that way when I am with a patient. I just listen to them, ask them what they want, and we negotiate together. My brain does not say, “Ah, this is a case for palliative sedation.” It just does not cross my mind. Perhaps in retrospect I might say, “Do I practise this? Do I sedate people to help them die faster?” No. But if someone is dying imminently and is very agitated and distressed, it is not the pain. They do not scream and say, “I’m in pain. Stop the pain.” The media might write that, but that does not happen. The person is saying, “I’ve had enough. I’m anguished. I’m despairing. I feel demoralised. I feel frightened.”

How do I answer your question? I am thinking very much of a patient who distressed me enormously last year. I want to present this without disclosing who this was. So I will just say that recently a patient in a hospital had an extremely severe disease of multiple sorts. Her body was failing and failing. It was awful. She had respiratory failure; she had a breathing machine. She was brought to hospital multiple times over a month or two. On the final admission when she came in, she was dying, and she said, “Let me die peacefully. I’ve had enough.” But the junior hospital doctor said, “I can make you better. Let’s just try one more course of antibiotics for a few days”, and she was persuaded to try one more course and so she was kept alive for a few more days. She said to me, “That was a mistake. I wish I’d been allowed to die. I feel terrible. I feel pain everywhere. Please give me more painkiller.” I thought, she does have pain, but this pain in her whole body everywhere is a sign of distress rather than physical pain. She said, “Give me more painkiller, more painkiller”, and I did, but it did not make much difference. Then I discovered the secret to her life. I found out the deep, dark secret that was troubling her. If this is too personal, you can strike it off the record. Her son and her daughter said to me, “We had another sister. She suicided at the age of 21, 15–20 years ago. Mum did not go to her funeral. Mum has not said her name for 20 years. That is still unresolved.” I find that sort of story very common for a patient who is extremely distressed at the end of life. Most doctors and nurses will say it is because of their cancer or their bad lung or their sore leg. But often it is some deep family conflicts and turmoils and a dirty secret. I do not say to the patient, “Before you die, spill the beans. Tell me. Confess your evil stuff.” I just listen and wait. Occasionally, the secret comes out and the person feels better having told their secret and they die more peacefully. If we jump to the conclusion that they are in severe pain or they are very restless and a high dose of morphine and benzodiazepine to sedate to them is a solution, we may feel better, and in the morning, the ward nurse may say, “Mary died last night; she was peaceful”, and everyone says, “Good, good”, but actually Mary was just drugged to death, she was sedated so deeply that she finally passed out, and the family issues, the sadness, the grief, are not dealt with.

I find this very hard with our young doctors. They are bright, they are keen, they are well trained. But they do not have life experience of suffering. I heard this morning someone who you asked, “What is suffering? How can suffering be good for you?” It is a tough one. I can address that more if you want me to.

The CHAIR: Please.

Prof. BRIDGE: I will answer by saying I give a workshop lecture to medical students for an hour, called “Suffering and Spirituality”. The very first time I come in, I say, “Are you going to die?”, and they all say, “Yes.” I say, “Hang on. Are you going to die?” “Yes.”

[2.30 pm]

I say, “You’ve spoken the truth; I can see in your face that you know that’s true, but there’s no emotion whatsoever. It means nothing to you. Tomorrow you’re going to the palliative care ward and you’re going to sit with a patient who’s dying. If you say to her, ‘Are you going to die’, she won’t say ‘Yes’; she’ll start to cry because it’s real. Really facing death is overwhelming.” We just do not do this; it is so horrible we do not do it. We live all our lives as though we are going to live forever. We go to work, we earn money, we travel but there comes a time when we face death. That suffering is really the first time many Australians have faced a serious trauma. We do not have famines; we do not have wars or pestilences.

On to suffering. At the end of one of my talks a senior medical student said, “Dr Bridge, I’m worried. I can see the benefit of suffering. I have not suffered.” I said, “Don’t worry; you will. You don’t have to seek suffering; it’ll happen. The question is when something horrible happens to you; when you finally do suffer, you have a choice of responding with bitterness and revenge or with forgiveness and peace. That is the big choice—whether that’s cancer, divorce, bankruptcy, imprisonment, whatever it is.” Who wants to be in prison and bankrupt and have cancer? Nobody. But something will get you, and you have a choice. Balfour Mount’s hero was Viktor Frankl, the Austrian psychiatrist and psychologist who was imprisoned by the Nazis. He had terrible suffering but he said, “He who has a ‘why’ to live for can endure almost any ‘how’.” If there is meaning in life, you can put up with suffering. If there is not, you disintegrate.

In the handout you have got already, do you have that with you or probably not?

The CHAIR: We can get it up on the screen.

Prof. BRIDGE: I like to find provocative quotations that make us think. One I am thinking of is in my presentation called “Making Health Care Whole”.

The CHAIR: Mr Bridge, while we are waiting to pull that up, is it your view that unrelieved distress at the end of life is always psychological?

Prof. BRIDGE: No; it is always complex and a mixture of physical, psychological, emotional. A lot of this stuff is subconscious. If you said to the patient, “What’s troubling you?”, they would not even be able to say. On the surface, it is often family conflict. When I first see a patient I say, “I have this strange habit of wanting to know the family. Would you mind if I ask you about your family? There’s you. Who’s this?” “My husband.” “Who’s this?” “My daughter.” “Who else is there?” I draw a family tree and that often reveals, “What about this one over here?” “We don’t talk to her.” “Why not?” “Stuff happened.” Who has a perfect family? Nobody.

That is the one at about the third page. This unusual character called Søren Kierkegaard, who is well known to philosophers and theologians, said this strange, stupid quote, “With the help of the thorn in my foot, I spring higher than anyone with sound feet.” “With the help of the thorn in my foot, I spring higher than anyone with sound feet.” Many people think that is ridiculous. If you have a broken foot, you cannot jump at all. But what he is saying is that the person who has been wounded and processed that wound and matured through it is a bigger person than the one who has drifted through life with ease. I would like to quote the next person. I ask the students, “Who knows who this is?” They never do. Aleksandr Solzhenitsyn was a Russian dissident, Nobel Prize winner. If you criticise the government in Russia, bad things happen; you get sent to Siberia. He spent decades in

Siberian prison camps. If you did not know about him, you would expect him to be bitter, angry, wanting revenge. That would be normal human behaviour. In fact, he says, “Prison causes the profound rebirth of a human being... Your soul, which formerly was dry, now ripens from suffering.” Really, a bit strange. “And that is why I turn back to the years of my imprisonment and say, sometimes to the astonishment of those about me: “Bless you, prison!”.” That is ridiculous. He is saying “after decades of horrible pain and suffering and injustice” that he is grateful; it was a good experience. I find that profound and true and if I am honest looking back at my life, the worst experiences I have had, that I thought would kill me or I thought would make me suicide, if I have now worked through those, they have become a source of strength. I have worked through a divorce, I have faced death twice, I have had some bad stuff happen and I can now talk about it because I think I have worked it through. I still have a couple of problems I have not resolved and I will not talk about them because they are private. Next year I might say that I have ticked that one off.

Hon ROBIN CHAPPLE: I really appreciate what you have presented to us today; it has been profound. One thing you did say at the very beginning is that you assess a person as moving into what I call the death phase; they are going to die. One of the things that sort of faced the committee is this determination of how you assess a person is going to die. Is it a day out, a week out, a month out? Is there a certain condition that determines your evaluation of a patient that they are in the throes of death?

Prof. BRIDGE: There has been a lot of research on this—a very big classic text book called *Death Foretold*, in other words “predicting death”, by Christakis. There is a huge scientific study. The simple message at the end was that when doctors say you have got two months to go or six months or a year, on average, they overestimate by three times. They say six weeks and the person dies in two weeks. They get more accurate in the last few hours. If someone is profoundly unconscious, breathing irregularly and all their blood tests are horrible, I can say, “They’re likely to die today or tomorrow.” If I meet someone in the street who is walking and talking, I cannot tell. I saw a patient in Northam six months ago. He came with his wife and said, “Today is a very bad day for me.” He looked quite well. I said, “Why’s that?” He said, “Well, two weeks ago, I saw the professor of oncology; he was very sad and depressed. He said, ‘I’m sorry, you’re going to die, not today but probably in two weeks.’

He said, “Today is two weeks; I’m still here!” He said, “The first two days I felt really miserable and I thought, ‘I don’t have to submit to this; I’m going to beat it.’” He lived for another six months and had a fantastic quality of life. We cannot dictate when a person is going to die. I get really quite angry when a patient says, “My oncologist gave me three months.” What? “They didn’t give you three months. What I hope they said was, ‘I’m guessing you will live for about three months.’” The patients may misquote what they are told.

Hon Dr SALLY TALBOT: Professor, the point at which I want to ask you this question; as you probably know if you have been following the hearings, we have been asking particularly medical practitioners whether there is sufficient protection in the law as it stands at the moment. In asking you that question, I suppose I want to home in on that moment in that story you told about the woman who was wanting to die; was brought back into hospital and the young intern prescribed the antibiotics. Is there a sense in which, at least in your teaching, your object is to encourage that young intern to give different advice at that stage? Can you respond to that first?

[2.40 pm]

Prof. BRIDGE: Can I just finish off that story and say that I had seen her the year before; I knew she was going to die very, very soon, but I felt really sad that she could not face up to this final grief. I

felt really uncomfortable as I wrote up the order that said to give more sedation, give more sedation. I thought, “I’m just killing her.” That was one of those unpleasant, ambivalent feelings: am I trying to kill her or trying to relieve her suffering, or both? I talked to the other staff and said, “What else can we do?” I think I made a mistake. I thought I was senior and skilful and a good communicator, and the truth is internally I said, “I think I can help this lady. I am going to sit down for an hour and chat with her.” But she did not respond to anything I said. I said, “What about ...” and I named her daughter. She went, “Get out!” She just threw me out of the room. I thought, “I didn’t do that very well.” She obviously had a complete block. She did not want to talk about this suicide daughter. Maybe I should not have tried to, but I felt trapped. She was dying in a day or two no matter what I did. She was anguished and grief-stricken and she just wanted to be knocked out. I could not—I kind of acquiesced and let her have increasing sedation, which I would call in retrospect “palliative sedation”. It was designed to take away her distress. I was not trying to kill her, but I knew she was would die.

But back to the interns, we teach our medical students all the time to fix, fix, fix. The treatments for cancer is chemotherapy and surgery. We do not teach them that treatment is to listen and to offer other alternatives. I think it is part of the whole of society. If you go to the doctor with some problem, you are asking for a fix, and you will probably get it and that is good. If you go to a doctor with an incurable, horrible disease, what do you do? You pretend it is all right.

Hon Dr SALLY TALBOT: So those cultural settings of medical practice, that is what you are talking about, is it not—one of your ambitions is to try to change that through your teaching?

Prof. BRIDGE: Yes.

Hon Dr SALLY TALBOT: Can I ask you then the second part of my question: if you were successful in doing that and the young intern’s default position was, “We won’t offer you anymore because you’re dying and you want to die”, are there adequate protections in the law as it exists at the moment?

Prof. BRIDGE: Against what?

Hon Dr SALLY TALBOT: To protect that doctor from not prescribing the antibiotics.

Prof. BRIDGE: I know several of are you lawyers; I am not a lawyer at all. I was told 20 years ago that there is a law that says that if you kill somebody you are guilty and if you do not save their life, you are guilty—failing to fix somebody.

Hon Dr SALLY TALBOT: Which does not bode very well for palliative care physicians, does it?

Prof. BRIDGE: No. I said, “Has anybody ever been convicted under that rule?” They said, “No”. I actually said that I would be happy to go to court and be accused of failing to prolong a death; I am sure I would be acquitted. That might provide some reassurance to other doctors.

Mr J.E. McGRATH: Further to what Sally was talking about, the incident you talked about the patient—the man who had cancer, and you knew he was close to death and you decided to take the mask off, but first you sedated him and then you took the mask off and then he died soon after that. Is that something that could have been borderline in terms of the law as it is today? I think that most people would think that you did the right thing. I certainly would—that is my personal view—and I meet a lot of people who say, “Well, my father got very close and in the finish they stopped the treatment,” and they felt that was the right action by the physician. How would you describe your action on that day under the law that doctors operate at the moment?

Prof. BRIDGE: I think the important legal principle here is what is the patient’s right. The patient always has the right to decline treatment. No doctor—in fact, if I said, “I refuse to take your mask

off, you must keep wearing it for another two days,” I believe legally he could take me to court and accuse me of battery and assault by assaulting him with a face mask that he did not want. So he has a perfect right to say—in fact, he said, “It’s been good for the last few days. It’s kept me alive. It’s been great but I don’t want any more. Now the position has changed. I want it off.” I knew if he took it off, he would feel terrible. But, I guess, a person looking at me would say, “Dr Bridge is a bit of the hypocrite here. He’s actually killing people here and there and pretending he’s not.” I have done this about 15 times with my colleagues and I have written a protocol at Royal Perth: if the patient with a mask says take it off, what do you do? It starts off saying, you consult widely with all the doctors, nurses and family and make sure everybody understands. You get the senior consultant to do this, not the junior doctor, so I need to sit there with the syringe. You tell the family who want to sit there while the person dies, “My goal is to stop breathlessness. It’s just possible that your father, when I sedate him, will breathe relaxed and just lie there without the mask and live forever. I’m not going to keep increasing the dose until he dies. The end point is not death; it’s comfort.” Some patients will die in two minutes; some will take four or six hours. I have never had a patient recover. When we give it, we are pretty sure they are going to die.

Mr J.E. McGRATH: You do not believe that law needs to be changed? You think that the physicians, doctors, can continue to carry out their work under that law and not be fearful of prosecution?

Prof. BRIDGE: I feel comfortable myself. I do not feel threatened. I do not know what the detail of the law says. I suspect it is sound and safe, but I fully believe that a number of my colleagues would be insecure. In fact, I presented this to the grand round at Royal Perth, and a senior colleague, a specialist physician said, “We can’t do this. The media might hear about it!” I said “So what? It’s perfectly ethical.” He obviously felt uncomfortable, as if in some way I was killing the patient.

Mr R.R. WHITBY: Professor, thank you for your evidence. It has probably been the most powerful the committee has heard. The form we had up on the screen in relation to someone who is dying, what became of that?

Prof. BRIDGE: The 10 points?

Mr R.R. WHITBY: Yes. The form where you advised what the treatment should be with someone who is dying—what the approach should be. You obviously put that together. What became of it? Was it used at all?

Prof. BRIDGE: I had my secretary print them out on sticky labels. I used to carry it in my pocket, so when I came to a patient who was dying, I would just paste it in there to remind me to remind the staff. At that time there was a thing called the Liverpool Care Pathway—an international pathway. It was good for a while and then it went bad. I thought it was so cumbersome; it was about 20 pages of stuff. I thought that we just wanted a simple, short statement to guide people. I did a survey of my own results. I thought, “How good am I at guessing?”, so I checked. Forty times I used this thing. One patient had been discharged. I rang up the nursing home and said, “Can you please tell me what day this person died?” They said, “He’s still alive,” six months later. So 39 of the 40 died in two or three days; one, I felt very embarrassed. I thought he was on the point of death and he woke up and got better, so we cannot always predict death.

Mr R.R. WHITBY: What was the status of that document within the hospital system? Was it just a guide for doctors, was it?

Prof. BRIDGE: I made it up and I used it as part of my notes.

Mr R.R. WHITBY: Did other doctors use it or was it just for you?

Prof. BRIDGE: No. The hospital is full of well-intentioned rules and regulations. I am sure if I put it up as a hospital policy, it would have gone through lawyers for six months and they would have said

that it is not well written. Even this, I had reprinted. They said that it has to conform to the hospital terminology grammatical structure. They changed it to “terminal nutrition”. I said, “No, it’s not. I want, ‘Is he hungry or thirsty?’ That’s the whole point of it.”

[2.40 pm]

Hon NICK GOIRAN: Can I just follow that up. I think it is a good question that has been raised by my colleague. On that form that we did see up on the screen there, I am pretty sure I saw the words “goals of care” on there somewhere. It immediately triggers in my mind evidence given by other palliative care specialists that there has been a trial in Western Australia of a patient goals of care program and I think we heard that there was talk about trying to roll that out more broadly. Is that in a sense the genesis of the goals of care, the Professor Bridge notes?

Prof. BRIDGE: It sounds impressive. I do not think so. To me it was always just a small time approach to save me time writing out the same thing again: “The patient is dying, do this, do this, do this.” I did write their name in personally.

Hon NICK GOIRAN: Okay, so it is not the genesis of it, but are you in a position to comment about the goals of care trial and whether there are similarities between that and the document that you have prepared?

Prof. BRIDGE: I have actually lost touch. I retired from Royal Perth five years ago. I know junior doctors love to write up charts and protocols, they can be very helpful, but I prefer to listen to patients and families. I find it very gratifying.

The CHAIR: Professor Bridge, you mentioned that in some circumstances people might say towards the very end when you are using sedation you are killing the patients and pretending that you are not. Could you tell us how you would respond to that in that circumstance?

Prof. BRIDGE: I would try to point out the medical diagnosis: Why is the patient sick and dying? How can a patient be wide awake and lucid on a mask? If they have had severe cancer, they tend to die, but it is with motor neurone disease and some lung diseases that they are helped with the mask. I say that the emphasis is on the patient. If that patient says, “I have had enough”, I have to check out that they are just not impossibly depressed, angry or upset for a day. When the whole trajectory is downhill and we know that dying is very soon, I try to put myself in their position. If I were in their position, would that be a reasonable approach? I have got a lifelong lung disease a little bit like cystic fibrosis. At the age of 19 I thought I was going to die at 40, that is what the textbooks said, but on my fortieth birthday I thought, “I am still here.” Five years ago I diagnosed stomach cancer in myself. I was wrong, but for a week I really thought I was going to die. I lost weight and felt sick and my whole psyche said, “It is your turn now, your turn to die.” It was a difficult experience, profound experience, which has changed my life since then. So now every day I think, “If you died tomorrow, would this be important?” If the answer is no, I do not do it; I put it away. I am decluttering my life. I have come here today. Do I want to talk to this committee? If I can be helpful, sure.

The CHAIR: We have heard today really about this concept of the value of suffering and you and others have stated that there is strength to be found in suffering. If you had the choice not to suffer, would you choose suffering?

Prof. BRIDGE: No, I would not choose suffering. If I chose suffering, I would find that would be pathological, psychiatric. A person who wants to suffer is sick. Life is a celebration and joy and for living.

I get a bit worried. I am always talking about dying and suffering and I have to be careful. Do I really want that? No. But people do not know how to suffer or die. They have this idea of “I have a right

to happiness. I have a right to wealth and health. I have a right to die.” I think that is a strange statement. We do not need a right to die; it is compulsory for everybody.

The CHAIR: Thank you, Professor Bridge, for your evidence before the committee. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added 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 an email for consideration by the committee when you return your corrected transcript of evidence. Professor Bridge, thank you very much for taking the time to speak to us today. It is much appreciated.

Hearing concluded at 2.54 pm
