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, 2 MARCH 2018

SESSION ONE

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

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Hearing commenced at 9.00 am

Dr LACHLAN DUNJEY
General Practitioner; Convenor, Medicine with Morality, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson; I am the Chair of the joint select committee. I will introduce the other committee members. We have Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Col Holt; Hon Nick Goiran; Reece Whitby and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in 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 might say outside today's proceedings. I advise that the proceedings of today's hearing will be broadcast within Parliament House and via the internet.

Would you please introduce yourself for the record?

Dr DUNJEY: My name is Lachlan Dunjey. I am a general practitioner. I have been in my own practice for 50 years, a graduate for 53 years. It is my privilege to be here. I am so grateful that this committee exists to discuss these things and I am very grateful to actually be here and to be able to present.

The CHAIR: Did you have an opening statement you would like to make before we begin with the questions?

Dr DUNJEY: Yes. First of all, I would hope that the results of the committee's deliberations will in fact enhance the commitment to palliative care in Western Australia, which I find is absolutely wonderful. If nothing else comes out of it, then if it enhances that, then that would be fantastic. Medicine with Morality was formed in 2006—I do actually have some brochures that detail what it is about; it also includes an invitation to join—to unite doctors across Australia in response to an increasing, what we perceived, drift away from traditional ethics in medicine and to preserve the liberty of medical professionals holding these standards to be able to practice medicine according to their conscience.

My mother died at the age of 47 from metastatic cancer of an unknown cancer in 1961 when I was just 20 and in third year medicine. She had been diagnosed four years earlier when a surgeon did a laparotomy and found that she was riddled with abdominal metastases and sewed her up and said she had six weeks to live. She was very unhappy about this and sought divine healing amongst other things. She transformed her lifestyle with carrot juice and went a delicate orange colour in the meantime, as they do. She had four years of excellent quality life with some 30 hospital admissions to drain the abdominal fluid, but that was about all. The last three months saw increasing cachexia with the weight loss to about 30 kilograms. She required no pain medication apart from her usual Bex, back in those days. On the day she died, she was lying on the couch in the backyard and calmly announced that she was going to be with God that night. Although many of the people who passed through her bedroom that night, extraordinarily, remarked how strong she was in giving her final messages to people, she died without distress about three o'clock in the morning. My father had taken his long service leave to look after her and I had just finished the year.

Needless to say, this experience has shaped my attitude to home care and allowing of natural processes where possible. I started my GP practice 50 years ago. I became familiar with the work of Dame Cicely Saunders early in the piece and Elisabeth Kübler-Ross. I have organised death and dying seminars on many occasions. It has been my privilege to look after my patients dying at home of cancer. No-one has died in pain. No-one has ever asked me to assist with their death, except early in the diagnosis when one or two have said they hoped that I would do the right thing by them, my response being a guarantee that I would look after them, and that they would not die in pain. The issue did not come up again.

The last few years, I have had four patients die, three of whom I had also delivered their children. They all died at home with the palliative care service assisting. I wrote some years ago for an Australia-wide competition on the passion of medicine and, for my pain, won two bottles of Grange —

> Which was it? Was it the thrill of the chase of the elusive diagnosis? The triumph of solving the puzzle? The entrée into people's lives? The adventure of saving life? The awe, excitement and responsibility of the birth? The presence during the last illness? The passion was the privilege of being there.

Thank you.

The CHAIR: Thank you, Dr Dunjey. Obviously, you are a very experienced GP. Do you practise palliative care?

Dr DUNJEY: For my own patients, yes.

The CHAIR: Is that as part of specialist palliative care training as a GP?

Dr DUNJEY: No, I have just gradually been with the process right from the beginning; therefore, I have been in communication with palliative care people as the practice has developed. So, no.

The CHAIR: We are going to start with some questions on palliative care. The committee has sighted a report which surveyed around 1 800 patients which demonstrated that around one to two per cent of patients have refractory symptoms around the end of life. We have also had evidence at this committee that it could be up to five per cent. Would you say that is a fairly accurate figure?

Dr DUNJEY: I would use the term "more difficult to treat" rather than "refractory"; I guess it means the same thing. In that context, yes, probably about one to two per cent sounds about right, although I cannot really recall any of my patients fitting into this category. When I have not been able to deal with their symptoms, I have sought help from the Silver Chain hospice staff, many of the nurses being very willing and able to advise on what I should be doing at that stage. But otherwise, the fallback, of course, was the consultant. The combination of care has never failed in my dealing with my patients, so nothing has really been refractory. In a sense, I think refractory means we probably have not been able to do it well enough.

The CHAIR: Do you think that medical practitioners rely on the doctrine of double effect when administering pain-relieving or sedating medications at the end of life?

Dr DUNJEY: The short answer is no. The question poses for me a dilemma which, for me, is not there and does not need to be there. We treat and we relieve the patient's symptoms. I find it weird that the double effect is referred to as a doctrine, almost as a protocol to be observed. It is nothing of the sort. It is an observation of what might happen, although as the reference quoted indicates, giving adequate doses of opiates may actually prolong life rather than shorten it. Double effect is sometimes touted, and has been for a long time, by euthanasia advocates to say that it is the same

as euthanasia and that, as doctors, we are already euthanasing patients and it therefore should be legalised and controlled and, of course, doctors would be protected. I see this as a deliberate tactical confusion and, in fact, I wrote a series of three articles in 2001 for a Baptist newspaper highlighting this. If I can make this clear, and to answer really the next question: "How do you distinguish the hastening of deaths", and I would put in there "that may occur", "as a result of the double effect from assisting in killing?", the latter is intentional—assisting in killing; the former is not. The former—the non-killing pathway—is reversible and the patient may recover. If the intention is to kill, then the process continues until they are killed. The two scenarios are polar opposites. In the minds of doctors committed to life and quality, there must be no confusion about this. They are polar opposites.

The CHAIR: You have made your views clear on the doctrine of double effect so this question may not be relevant, but do you consider the current law in Western Australia adequately protects medical practitioners who rely on the doctrine?

Dr DUNJEY: Yes, I do. I think it would take malicious prosecution and a misguided judge or jury to convict any doctor acting in accord with best practice palliative care.

The CHAIR: Given that opioids are a high-risk medication, do you think there is a risk of under-dosing at end of life?

Dr DUNJEY: Sure, and I think this is a function of requiring more palliative care and more reassurance to the doctors who might be a little bit timid in this area, and giving them confidence they are not, in fact, killing the patient. This is something that a doctor is going to struggle with, perhaps more than a good law and more than anything else, but with their own conscience—that we do not want to shorten the patient's life. What we want to do is to fix their symptoms and help them to have good quality at that point. So, yes, I think we might have a fear of under dosing, but I do not think it is because of the law, and I do not think it is a fear that someone is going to say that this is a double effect, and therefore it is euthanasia. So, yes, we need reassurance in this area so that we can give adequate doses and good palliative care.

[9.10 am]

The CHAIR: Do you have a view on whether or not administering the gradually titrated sedatives or opiates would hasten death?

Dr DUNJEY: If it is a deliberate, pre-planned pro forma, regardless of clinical response and changing circumstances, then yes, it may hasten death, but if a patient's condition is monitored and treatment appropriately modified, then the patient can have more quality time and death even prolonged, and certainly I have had patients who have hung on for various reasons, even so that I could depart on an overseas trip, the next day, with the patient concerned actually then dying the day after I left. The last afternoon before our early morning departure was extraordinary, as Jack—which is not his name—had his multiple family all there and Jack showing remarkable resilience and being very much in charge of the situation reclining in a large chair. It was a lovely afternoon, and they let me know the next day that, yes, he had in fact passed on.

Hon ROBIN CHAPPLE: Thank you, doctor. You say that you use palliative care. Quite clearly, we are hearing that there are specialist palliative care providers, and there are others who more broadly use palliative care. This is very subjective, but how many doctors do you think actually, like yourself, develop skills around palliative care whilst not actually having that formal training?

Dr DUNJEY: I really do not know. The doctors that I come across, the GPs in particular, whom I know, all tend to be much along the same lines as myself, that they enjoy the practice of medicine, they like looking after their patients. They have not always had the opportunity of delivering their

children, which I had for 20 years. I think they do look after their patients at home and, of course, when necessary call in the palliative care people. I know that some of the doctors who have been my friend GPs for many years in fact now, when I ring up and say I would like some advice, they are the ones who in fact give me that advice. They have gone on further with the palliative care service and, if you like, become a palliative care service consultant. How many doctors? I would hope it would be between 10 and 20 per cent.

Hon ROBIN CHAPPLE: That is very interesting, but thank you for that. You also talked about articles you wrote for the *Baptist News*, was it?

Dr DUNJEY: Yes.

Hon ROBIN CHAPPLE: Do you think you could provide us with copies of those? It would be useful.

Dr DUNJEY: Yes, I have got a copy here, in fact.

Hon ROBIN CHAPPLE: Right, okay—ahead of the game!

The CHAIR: You said you have had a number of patients die in your care—a small number. How many of them died in hospital?

Dr DUNJEY: In recent years, no. There are some that do require it in the last phases. I think I am probably going back a decade at least before that has been the case. I have been fortunate, I suppose, in the ones that I have had, but, yes, at least a decade.

Hon COLIN HOLT: Do you think attitudes from the patients have changed over the years, with more and more people wanting to die at home, rather than in hospital?

Dr DUNJEY: I think that has always been the case, yes. Some people these days just have the idea that they will have to die in hospital. I am at pains, very early in the piece, to say that this does not have to be the case and, yes, we will do that if we need to for such-and-such a reason, but if we can keep you at home, that will be good. There is a lot of fear around that, particularly with the other carers, but then it is my privilege to explain that and allay some of those fears, particularly as time goes on, and I always give them the option. So, if we need to do this, yes, this is what we are going to do. This is not something that you have to go through with at home if things are not working for various reasons. There is always that option of saying no to that pathway and, given that confidence, that helps them to go along the pathway being looked after at home.

Mr J.E. McGRATH: I have got a general question, and I guess this goes to the crux of why you are here today. You have indicated you are definitely against assisted dying or euthanasia or physician-assisted suicide. If it came into being in this state, that it was legislated for by the government, where would you see the people who would want to take it up coming from? I have a view that people really do not want to die. People go to the doctor and they try and hang on as long as they can. Do you see it in this area of people in the last days of their lives that you are treating and trying to give them palliative care and make them as comfortable as possible or would you see it may be coming from another cohort? Where do you think the take-up would be, and do you really think it would be a bigger take-up, given that a lot of people would prefer the option of good palliative care?

Dr DUNJEY: Sure. For the patient going along the pathway, I hardly ever see it coming up. With the relatives, sometimes this is a thing, out of concern, obviously, that we do not want to see our loved one put through this; is there any way that you can help? Otherwise, in the general community, do you mean?

Mr J.E. McGRATH: Yes—other diseases like motor neurone, Parkinson's disease, or those sorts of things where people's quality of life has just become unbearable, but they are not going to die

tomorrow. They might have three or four years to live, but it has become so difficult for them to live an ordinary life and to do the things they would like to be able to do.

Dr DUNJEY: With my patients in that situation, once again, it has been a matter of talking through the process and what that ultimate process might be, and then how we might manage it. In that situation, once again, I have not come across requests for euthanasia. I am aware that, out in the—they are my patients; the ones that I have a chance to deal with, but otherwise, yes, I am aware that there is a push that we should allow—particularly young people, I think, have got this sense that, "I want to be in charge of my life, I want to die at a time of my choosing and in the manner of my choosing." I think that that is an increasing move, and I would hope that as a result of this kind of committee's deliberations, that we might be able to change some of that. When we get in a situation with a patient with a problem, then we get to talk about it, and the automatic push is, "Yes, of course I want someone to kill me and put me out of my misery", which might just be an automatic gut response in a high percentage of our population. Once we get into the situation and talk about it and we, first of all answer their questions that they ask particularly at a point of need—"Will I die in pain?"—then we can go on how we are going to be able to help that.

Mr J.E. McGRATH: Just one further question. So you could not see the two systems running together—the palliative care option and then, if someone has a real serious wish to terminate their life, running parallel so that people have that choice? You could not see that working?

Dr DUNJEY: Not with doctors involved in that process, no. For doctors, our thing is to maintain quality of life as long as possible, but maintain life. For doctors to be involved in both of these processes—no, it is not something that we can do and maintain our intrinsic care for people. It is not something that we could do. We would have to be some other process, but not doctors.

[9.30 am]

Hon ROBIN CHAPPLE: Just on that, doctor, the Victorian legislation, which has yet to actually come into effect but has been enacted, has two options. One is to allow for medically-assisted dying, and the other is for patient—what is the word I am looking for?—administered dying. In the context of what you have just said, you would not support doctor-assisted dying, because you believe it is morally and ethically the responsibility of doctors to maintain life. Where do you go when it comes to the other option, where a patient is self-administering end-of-life action?

Dr DUNJEY: I would like to be able to talk them out of it and once again go through how we can assist the process without having to resort to that as a last choice.

Hon ROBIN CHAPPLE: So your values are over both issues, not just the doctor's moral and ethical responsibility?

Dr DUNJEY: Yes.

Hon ROBIN CHAPPLE: Thank you.

Hon NICK GOIRAN: Further to that, Dr Dunjey, what are the risks of patient-administered suicide?

Dr DUNJEY: It may not work. It may in fact increase their problem. They might have a cerebrovascular accident as a result of what has happened. The distress of them waking up when it has not worked I think must be an extraordinary emotional stress. So, yes, it does have its risks.

The CHAIR: We have talked this morning already about how we have had heard evidence about that shift to accept patient autonomy and self-determination. Would a decision to treat in a manner which may hasten death be a decision by the patient or their doctor?

Dr DUNJEY: Unless the patient is actually requesting euthanasia, then I think this is also an artificial scenario. In practice there is a continuing discussion as to distress and relief of that distress. If there

a hint of ambivalence by the patient, then what is required is a firm commitment by the doctor to care, and something like, "Yes, the pain management at the end may hasten your passing by a few hours, but it may equally give you more hours of time with your friends. We can be in control of this together."

The CHAIR: We have also heard quite a lot of evidence about the practice of terminal sedation, or sedation at the very end of life. Do your members ever raise concerns regarding this practice?

Dr DUNJEY: No, but their concerns would be the same, I think, as mine, that terminal sedation might be used in the form that I think the now discredited Liverpool Care Pathway may be used as a form of euthanasia. I think they would be the concerns that they would share.

The CHAIR: Are you as a GP ever required to assess capacity?

Dr DUNJEY: No. I have been asked, and I refuse, because I am not competent to do that—not in terms of legal things, no.

The CHAIR: What about around decision making around medical treatment?

Dr DUNJEY: I would assess that myself, yes.

The CHAIR: Can you elaborate on that, and in what circumstances you would refer that to a specialist, and which specialist?

Dr DUNJEY: Again, this is artificial for me. The ones that I would be talking about would be people at home who are with their relatives, and in that circumstance I am able to judge whether or not that person is able to give me a rational answer. So, no, I would not be referring those people. In terms of advance care directives and things like that, once again, if I was happy with their mental state, yes, we can go through a mini mental state examination, and, yes, I am competent to do that. No, once again I have had no need to refer on for other assessment.

The CHAIR: Touching on the practice of terminal sedation, I think I am hearing that is not something that you practise or that your members practise?

Dr DUNJEY: I would do that in conjunction with a palliative care specialist, yes.

The CHAIR: In what instances would you see a terminal sedation as appropriate?

Dr DUNJEY: Where the symptoms are in fact so severe. I can give you another case scenario of my brother-in-law, who I will call Mr X, who died about 16 months ago, where the change in therapy while in hospital from acute care to palliative care worked really well, the decision being worked out by the medical and neurosurgical teams—he had brain secondaries—in consultation with X and then with the palliative care consultant, who talked with him on the Thursday and the Friday and then arranged a transfer to a non-acute hospital with a palliative care unit on the Monday. We saw X again on the Monday morning. I was there at the time, before the transfer that day. The next day we had a fantastic day, with lots of people visiting. The next morning, he had cerebral irritation, agitation, I suppose, terminal delirium. He was certainly not able to hold a conversation at that point. I would regard that it would be terminal sedation that was in fact administered at that point, and he died later that afternoon, so it was a "good" death. The day before was a day of excellent quality, and he had the severe problem the next morning, which I am pretty sure was the brain secondaries, but there may be chemical things which come into that. At that stage, there was no recovery. So he was sedated, and death took place naturally the same day.

Hon NICK GOIRAN: Further to that, Dr Dunjey, the committee has asked a lot of questions about terminal sedation, and different practitioners have clearly been talking about different things. Can you just, particularly on that last example that you gave, define for us what is meant by terminal sedation?

Dr DUNJEY: It was increasing amounts of opiates. There may have been other major tranquillisers that may have been administered at that point. I was not in charge of that process but I was comfortable with the process. That was it. As far as I am concerned, there was no deliberate attempt to kill him. It was relieving the symptoms. So there would have been some other psychotherapeutic agent which was added to that. I had confidence in the person who was doing it so I did not actually ask what those agents were, but something like Stelazine is what we would have used in the past in that circumstance, together with opiate.

Hon NICK GOIRAN: In that phase of sedation, would it be common for a patient to—I am going to use the word "revive", but perhaps there is a better word to use—revive from that sedation during that process?

Dr DUNJEY: With this particular person, the answer would have been no because of what was happening cerebrally with his cerebral tumours, and sometimes also some peculiar chemistry is going on which causes that. So in that instance, no. The lack of recovery in that instance is in fact due to the actual disease process. In other instances, where perhaps there is just an ongoing pain situation and a lot of distress, increasing the amount of opiate at that point, but then in fact lessening the dosage and sometimes the patient then is able to achieve—okay, I am reading this. I am not experiencing it. I know that that can happen and that then at that point they can recover and have some more time of quality before the deterioration occurs, because we have managed to relieve the symptoms. But I have not actually experienced that with my own patients.

Hon NICK GOIRAN: So sometimes the patient revives from the sedation and then sometimes not?

Dr DUNJEY: Correct.

The CHAIR: In those instances, would you consider it a reportable death under anaesthetic?

Dr DUNJEY: No.

The CHAIR: Are there any other questions on this issue?

Hon ROBIN CHAPPLE: Obviously my perennial—do not resuscitate. We hear a lot about the application of "do not resuscitate" on hospital beds and that sort of thing. Is that something that you have experienced? What are your views on "do not resuscitate"? Who do you think actually makes that decision?

[9.30 am]

Dr DUNJEY: It is a long time since I have come across that. Speaking from past knowledge and how I think it should be, it should be a decision which is made by a person who is, at that stage, presumably not competent, so it would be a decision made between the medical staff and the relatives concerned. That sometimes can be a difficult pathway. I did have one unfortunate experience very early in my practice having a teenager die of brain tumours, and when in fact he had a cardiac arrest, he was resuscitated and lived another day or two or whatever before the brain tumour finally had its terminal effect. It was a very sad thing to happen. That was back in the days before we put DNR on the patient's bedhead. The doctor coming in, as a response to this person having a cardiac arrest, did what a doctor does, and then found out otherwise afterwards that in fact his disease was terminal. The parents were very angry that in fact he had been resuscitated in that particular instance. Do I think it has a place? Yes, I do, but it needs to be worked out with the doctors and the relatives concerned.

The CHAIR: In relation to palliated starvation, do your members ever raise concerns regarding palliated starvation?

Dr DUNJEY: Do I have any concerns?

The CHAIR: Or your members.

Dr DUNJEY: I would presume that they would have the same concerns as I have. Terminal sedation on its own is one thing; palliative sedation in combination with artificial withdrawal of food and fluids I see as being wrong. Besides that, in fact it adds to their distress with not being able to have their mouth moist—so, no, I see that as being a wrong procedure, unless the patient has requested it.

The CHAIR: Unless the patient has requested it?

Dr DUNJEY: Yes. As in the Rossiter instance, yes.

The CHAIR: In the instance where you consider a competent patient decided to withhold or withdraw from any nutrition and hydration, where would that leave you as a medical practitioner?

Dr DUNJEY: Can you say that again?

The CHAIR: Yes. Sorry, I could have put that better. In the instance where a competent patient has decided to stop eating and drinking in order to bring about an earlier close, if you like, or bring about their death more imminently, how would you treat that patient?

Dr DUNJEY: I would love to talk to them about their distress that they might get from being starved and dehydrated and that we have other ways of handling their symptoms and other ways of, hopefully, prolonging their life with some quality so that they can talk to their significant others, and that there is another way of doing it.

The CHAIR: What is your view of withholding or withdrawing from nutrition or hydration while sedated?

Dr DUNJEY: I am not happy with that.

The CHAIR: You are not comfortable with that?

Dr DUNJEY: No. I see that as being a form of euthanasia rather than good palliative care.

The CHAIR: Do you think this is recognised as a common treatment?

Dr DUNJEY: No.

The CHAIR: You touched on the Rossiter v Brightwater case. In relation to that case, do you think that a person's right of refusal of treatment is now clear for medical practitioners?

Dr DUNJEY: Yes.

The CHAIR: In regard to futility, doctors are not under an obligation to administer futile medical treatment. How do your members assess whether life-sustaining treatment would be futile?

Dr DUNJEY: We are individual doctors with individual practices, we practise and teach independently, we are guided by our own training and experience in working with palliative care physicians. We have remarkable unanimity with good clinical judgement in assessing whether further care is futile, whether that is from a point of view of symptom control or whether in quality of life or length of that life. I consider this to be a reflection of how good our palliative care services are in Western Australia.

The CHAIR: A Canadian study found there was extreme variability amongst ICU careworkers in factors around decisions to withdraw life support. Do you think we would see the same variability in Western Australia?

Dr DUNJEY: No, I do not. I think in palliative care areas we are in fact likely to be, as I said before, in good unanimity in this area. ICU is quite different.

The CHAIR: In relation to voluntary assisted dying, we have had some evidence that euthanasia is practised in various forms underground, if you like. There is a view that this is a covert practice by quite a large number of doctors and that the community's interests would be better served having a regulated assisted dying program to protect the community. What is your view on that?

Dr DUNJEY: I hope my scepticism does not come through too much. I have reservations about academic assessment in this area. I think good physicians who react appropriately will increase medications for distress that may hasten death by hours and will admit to doing this, feeling to a degree uncomfortable because they have done it when there has actually been no intention of hastening death, but when being questioned on this, they may say, "Oh, yes, I've done this", and then it has been assessed as being that they have actually deliberately hastened the death but without any actual intention. I see this once again as being good clinical care and not euthanasia. The level of medication at that instance is reversible, and conscientious but perhaps timid doctors need affirmation that such is good medicine and not to be confused with euthanasia. It is not the doctors in this situation who wish regulation. Sometimes it is the observing academic who wants to have adequate statistics for analysis. I would say let the doctors in the field get on with the job of doing what they do well.

The CHAIR: Noting your objections to voluntary assisted dying, if a scheme or legislation was introduced in WA, what protections would medical practitioners require under the legislation?

Dr DUNJEY: I think the protections given by the Universal Declaration of Human Rights of 1948 and the International Covenant on Civil and Political Rights 1976 to ensure that the abuses of the Third Reich would never ever be repeated would be sufficient. There should be no place for doctors to be compulsorily involved in euthanasia or physician-assisted suicide or voluntary assisted dying—never. It is important to note in both of those things that the right to manifest religion or belief in worship, practice and teaching is also stated by the International Covenant on Civil and Political Rights, in article 4, that this right is a non-derogable right; one which cannot be overridden even in national emergency. That sounds to me like a pretty strong statement.

The CHAIR: What is provided for under current ethical guidelines in relation to referrals to other providers in circumstances where a practitioner holds a conscientious objection?

Dr DUNJEY: At the present moment, the answer is yes to that. In item 2.4.6 in "Good Medical Practice" by AHPRA—I keep on calling it the Medical Board; you know what I mean—"A Code of Conduct for Doctors in Australia", it is —

> Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

This is a little bit difficult in terms of how different people see this. In Victoria, a section 8 law compels doctors to refer. In fact it is not necessary because such referral is not necessary. They can go and see another person. They can go direct to an abortion facility anyway. In that instance, a referral is not required.

[9.40 am]

We would see such a referral as being against our conscience. I think most of the doctors of Medicine with Morality would say we would not want to be part of that process. Similarly with euthanasia, if in fact a compulsory thing was brought in. Relevant to that, as I am sure you know and other people have talked about it, is the recent decision by the Ontario Superior Court of Justice that has unanimously ruled that notwithstanding religious convictions to the contrary, Ontario physicians

can be forced to help patients access any and all services and procedures, including euthanasia and assisted suicide. I am sure you are aware of that legislation.

The CHAIR: We have been made aware; we have heard evidence.

Dr DUNJEY: Okay. Commenting on a decision, Professor Roger Trigg at Oxford said once the perceived interests of the state override the moral conscience of individuals and, indeed, of professionals, particularly in matters of life and death, then we are treading a slippery slope to totalitarianism. I might add then that the medical profession faces many challenges for the future. The challenge of conscience, belief in practice, is fundamental. If we damage a relationship between doctor and patient where patient health is our primary goal, our reason for being, then all of medicine will have been damaged. I would not want us to go in that direction. We submit that it is not enough for doctors to simply be providers of medical services on consumer or state demand, providing all that is legal whether or not it is consistent with our ethical base; to sacrifice conscience and be concerned only with service provision is to destroy the heart and soul of medicine and turn doctors into killers. Medicine and society would be the poorer. We must not go there.

Mr J.E. McGRATH: Doctor, you spoke before about patient-administered dying. You had a problem with that because you said, "Well, what if it doesn't work; what if they take the drugs thinking they won't wake up and then they do and there could be some side effects?" We have been told by a number of providers of palliative care that they think end-of-life choice is inevitable. It will come about because the public is pushing for it and they want that choice. If the government did legislate to go down this path, and doctors were not compelled, so they could opt out, if a doctor for many reasons did not want to be involved in providing the end-of-life facility, do you think that it could work if there was no patient-administered capacity and it was left to only doctors who were prepared to do it, rather than just have someone be able to have some concoction prepared for them and take it home and use it? We are told that some people do not even use it once they get it. To me, that seems a bit risky, whereas when things are handled by your physician, who are trained people, I would have more confidence in that. So if it were to come in, what part of it would you not agree to, if something had to happen?

Dr DUNJEY: Once again, for the medical profession, it would create a problem in terms of saving life and taking life. We do not want to be confused. It is a problem for the medical profession. Secondly, we do not want patients to see us as curers sometimes and killers on other occasions. This leads to a problem with the patient's mind in terms of how they see their doctors. Bringing up the whole problem of suicide, we do not want suicide to be seen as a valid option by the general community. We have funds going into suicide prevention in Australia and I would see, if this was a legal option, that this would undercut some of the other good stuff that we are trying to do. Our answer on this would be: there is always a way out; there is always something we can do. We want to help. We want to encourage care. We want to encourage people to talk about their wish to die. In the instance where a patient is ill or suffering severe disability, once again, we would like to say, "Let us help you with the problem. Let us help you to look at alternatives other than dying." This is what we do as doctors. To give a legal imprimatur or permission to suicide, I think is dreadful for the community. I do not think that is good. It is bad for the medical profession; it is bad for the relationship between doctor and patient; and there is always another hope that we can give in that situation. Whether it is as a result of depression—depression in conjunction with whatever else is going on medically or depression on its own—or whether it is just because they have a handicap and how to deal with that and how else we can look at that, the medical profession is always going to be hope: "Let us help you with where you are at the present moment in this particular situation which is causing you to think along this direction. Let us look for another way out, and I believe there is another way to help."

Mr J.E. McGRATH: Basically, your position is no?

Dr DUNJEY: No; correct; you have got it.

Mr J.E. McGRATH: No to everything. Even if it came in, you would still be totally opposed and you would look at there being some way it can be managed in the best possible way for the community?

Dr DUNJEY: Yes, and I seriously believe there would be a division in medicine. There would be a large number of doctors—I think the Canadian experience has given an idea of this—that are uncomfortable with the process. I would hope maybe 90 per cent of doctors would say, "No, we're not going down this line." There might be another 10 per cent that might accede to that.

Hon COLIN HOLT: You have mentioned a couple of times now how good palliative care is in WA.

Dr DUNJEY: Yes.

Hon COLIN HOLT: I suspect that is from your own patient experience. What about a broader level in the system; are there any improvements you can see that we could take on in terms of how we can improve the palliative care system?

Dr DUNJEY: I think it can always cope with more funds in order to ensure this. I think the teaching in medicine is good. I am not sure how that works in medical school but, certainly, the experience I have had with palliative care physicians, growing up in medicine along with these people, it is very, very good. We are so privileged in Western Australia; we are so privileged in Perth and I realise that in the country it can be a more difficult situation. So as long as we never, particularly if we pass something along the physician-assisted suicide–voluntary assisted dying line, see this as a reason for reducing the funds to palliative care, as has happened in other places or where treatment for the patient has been restricted—"Yes; we will help you to die, but, no, we are not going to help you with this chemotherapy because that is more expensive"—that must never become. Yet the tendency, I am sure, would be there for government to say, "This is a much cheaper option; let's go to that instead of palliative care", which is essentially an expensive option but one which we must hold to. I am sure we will. We will struggle through any of those other difficulties to maintain the standard of palliative care in Western Australia and to see it more widespread.

Hon NICK GOIRAN: Dr Dunjey, is there some form of palliative care that is being practised or is available in Western Australia but only if you are a holder of private insurance and not under the public system?

Dr DUNJEY: No, definitely, absolutely not. No; it is available to all, yes.

Hon NICK GOIRAN: So long as you are living in the metropolitan area!

Dr DUNJEY: Yes, precisely.

Hon Dr SALLY TALBOT: Can I ask you to talk about the state of the medical professional currently. You referred a couple of times to your fear that if voluntary assisted dying is legislated, there would be an irremediable split in the medical community. Is the medical community currently completely united on all these issues?

[9.50 am]

Dr DUNJEY: I think so; yes.

Hon Dr SALLY TALBOT: Are there other issues that cause this kind of division within the medical community?

Dr DUNJEY: I cannot think of any.

Hon Dr SALLY TALBOT: So things like sterilisation, artificial conception, abortion?

Dr DUNJEY: Yes; of course, yes, particularly with the abortion area. There are some voices that are quite strident on that and, as has happened overseas with the American College of Obstetricians and Gynecologists, saying to a person who is in a remote area, "If you're not prepared to practise medicine and do abortions in that area, then you need to leave that area and go somewhere else." So, yes, there are. Of course, we have Professor Julian Savulescu in Oxford who says that physicians, unless they are prepared to do what is legal, should not be in medicine—should not practise medicine. I see that kind of attitude as destroying the whole fabric of who we are and that going down that line is extremely dangerous. So, yes, there are people there who do that. My namesake in Victoria—beginning with Lachlan—goes down that direction as well. Did I answer your question?

Hon Dr SALLY TALBOT: Yes. So you are saying that the medical community is currently split by some of these?

Dr DUNJEY: A small split, yes.

Hon Dr SALLY TALBOT: A small split? What is a small split?

Dr DUNJEY: I think the Julian Savulescus in Oxford are out on their own and that the majority of doctors, first of all, are united in caring for patients and not to become killers, and that we are committed to quality of life, quality of care, in all instances. Yes, I am aware that there are some who will say, "I want autonomy in my life and to die at the time of my choosing and, therefore, I will give this to other patients, and I am happy to euthanase them when the time comes." I do not know—I still think that doctors would have hesitation at that point. They might say, "Well, okay, I'll take the risk on this and perhaps give a little bit more opiate." I think we would all have the difficulty of our conscience on this, particularly in the euthanasia area. Do I think that there is a section of the profession that is in favour of euthanasia and in favour of performing it? It must be so small. I have never come across such doctors.

Hon Dr SALLY TALBOT: I think that the distinction we are talking about is doctors who would be in favour of patient choice on the issue.

Dr DUNJEY: Yes.

Hon Dr SALLY TALBOT: I am hearing what you are saying, that you are eliding the distinction between a doctor's personal preference for herself or himself and the service he or she provides to the patient. Are you suggesting that—I am still probing into this small split idea—you are not surely suggesting that the majority of doctors are opposed to performing or advising about abortion? Abortion is a legal option for a patient.

Dr DUNJEY: We are on abortion, are we?

Hon Dr SALLY TALBOT: No, I am teasing out this idea. In your value statement you talk about the drift of ethics away from moral absolutes.

Dr DUNJEY: Yes; correct.

Hon Dr SALLY TALBOT: I am just asking you about the current state of feeling within the medical community.

Dr DUNJEY: I think we would all be thinking the same way on the euthanasia issue. There are doctors in Canada who are saying, "We are very uncomfortable with this process. Initially, we thought it was okay. Now we are uncomfortable; now we don't want to have anything to do with it." So when it comes to the actual crunch of administering something which is going to kill a patient, I think it is going to be pretty close to 100 per cent of doctors who are going to be pretty uncomfortable with that.

Hon Dr SALLY TALBOT: I am sure you are familiar with the way that the AMA is structured in Western Australia. Are you a member of the AMA?

Dr DUNJEY: Yes.

Hon Dr SALLY TALBOT: You would know that they did a survey in 2016 that showed that 25 per cent of doctors were willing to participate in some kind of voluntary assisted dying program.

Dr DUNJEY: Right.

Hon Dr SALLY TALBOT: Do you think that is wrong—do you think the result is wrong?

Dr DUNJEY: I think that what it the comes to the crunch of actually doing it, like the Canadian doctors, they will find that they are very uncomfortable with it, and that although they are in favour of it, even from a point of view of patient autonomy and patient choices, that when it comes to the crunch, they would be very uncomfortable with that. So I would hope that figure of 25 per cent would dwindle dramatically. I think when doctors are responding—it depends, of course, on what the survey question is like, just as with canvassing opinions in the general public—we might find that an 80 per cent plus rate might suddenly reduce to 20 per cent once the ramifications of whatever is being discussed are, in fact, dealt with, and the consequences of that kind of procedure. So it is, I am sure, that with doctors that 25 per cent might be quite artificial, depending on the questions asked and because they have not actually thought through it, like members of this committee have had the opportunity of doing. It is like the patient who says, "Yes, I want you to put me out of my misery when the times comes," but as we go through the process, suddenly they change their mind, and with the palliative care services that are available, once again they change their mind. I think once the doctors get into that situation, look at the ramifications and look at the total picture, I reckon that 25 per cent is way wrong.

Hon Dr SALLY TALBOT: With the greatest respect, I suggest that you would be offended, not to say distraught, if people who took a contrary point of view came in here and argued in such a way about the contrary position. I just ask you to reflect on that.[1]

Hon NICK GOIRAN: Dr Dunjey, what this really boils down is the right to conscientious objection. You indicated that if there was going to be some legalised suicide regime in this state, that you would want to ensure that doctors retain their right to conscientious objection. In Western Australian practise, is that right to conscientious objection in place?

Dr DUNJEY: Yes.

Hon NICK GOIRAN: In every aspect of medical practise in Western Australia?

Dr DUNJEY: Yes.

Hon NICK GOIRAN: Is that the same in Victoria, to your knowledge?

Dr DUNJEY: No. The section 8 provision of the Victorian abortion law in 2008 compels the doctor to participate in the referral process; not only that, it actually compels the doctor to participate in an abortion—that the doctor will actually provide it—when, in fact, most of those doctors would not have a clue how to do an abortion. Yet that law also compels me to do it, which shows how extraordinary that became.

Hon NICK GOIRAN: Contrary to any implication that the position of Medicine with Morality with respect to this issue of right of conscientious objection might be fearmongering or anything like that, the basis of it is actually the Victorian legislation and jurisdiction which causes you this concern?

[1] Correspondence from the witness clarifying this part of the transcript can be accessed on the committee webpage."

Dr DUNJEY: Correct.

Hon COLIN HOLT: I realise we are going over time, but have you been involved with Medicine with Morality since its inception?

Dr DUNJEY: I started it. I founded it.

Hon ROBIN CHAPPLE: In 2006, I think.

Dr DUNJEY: Yes. I founded it in Australia. I realised at the point we were in fact discussing, oddly enough, the RU486 thing, that we had doctors—prominent people—saying, "Religious people should not be involved. There's no room for this. We want to establish this on evidence-based medicine alone." I made the point then that if we are considering methods of abortion or euthanasia, evidence-based medicine is not enough. We cannot consider these things in a moral vacuum. I realised that we did not have enough force in Australia to be saying, "Yes, there are issues of morality that come into this, not just evidence-based medicine." That is why I formed Medicine with Morality.

Hon COLIN HOLT: That was going to be my question: what was the catalyst for forming it. You said —

Dr DUNJEY: RU486, which was chemical abortion.

Hon ROBIN CHAPPLE: You established the organisation in 2006.

Dr DUNJEY: Yes.

Hon ROBIN CHAPPLE: Is your organisation just restricted to doctors?

Dr DUNJEY: No, we have two ways of signing into the belief statement: one for doctors and one for ancillary-type people who are involved in any way in any of these ethical issues, so it includes other professionals. It includes physiotherapists. It includes nurses, of course. A lot of nurses have joined on to the ancillary network. It also includes teachers or other people who are involved. I would like to extend an invitation to all of you people.

Hon ROBIN CHAPPLE: Politicians can join.

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

Thank you very much for your evidence today.

Hearing concluded at 10.00 am

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