VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

ADMINISTRATIVE DIVISION

REVIEW AND REGULATION LIST

VCAT REFERENCE NO. Z164/2016

CATCHWORDS

Health Practitioner Regulation National Law (Victoria) Act 2009 ss 156, 157 and 202; condition imposed by Medical Board of Australia on practitioner's registration as a form of immediate action; whether sufficient evidence before Board to form a reasonable belief that practitioner posed a serious risk to persons and that it was necessary to take immediate action to protect public health or safety; s 156 criteria not satisfied; Decision of Board set aside.

APPLICANT	Dr Rodney Syme
RESPONDENT	Medical Board of Australia
WHERE HELD	Melbourne
BEFORE	Judge Jenkins, Vice President Dr Brian Collopy Member Dr Patricia Molloy Member
HEARING TYPE	Hearing
DATE OF HEARING	21, 22, and 23 November 2016
DATE OF ORDER	20 December 2016
CITATION	Syme v Medical Board of Australia (Review and Regulation) [2016] VCAT 2150

ORDERS

1. Pursuant to s 17 of the *Open Courts Act 2013*, the Tribunal orders that any material or information arising from this proceeding which could reasonably lead to the identification of the notifier, shall not be published or broadcast or be made available to the public. In making this Order the Tribunal is satisfied that it would be contrary to the public interest for the name of the notifier to be published.
2. The application for review be granted.
3. Pursuant to s 202(1)(c) of the *Health Practitioner Regulation National Law (Victoria) Act 2009*, the decision of the Medical Board of Australia on 5 February 2016, to impose a condition on Dr Rodney Syme's registration as a medical practitioner, as a form of immediate action pursuant to s 156 of the *Health Practitioner Regulation National Law (Victoria) Act 2009*, is set aside.

NOTE

The Tribunal acknowledges that prior to giving evidence, Dr Syme claimed that during the course of his evidence, the production of certain documents and answers to certain questions might tend to incriminate him. Accordingly, pursuant to ss 105(2) of the *Victorian Civil and Administrative Tribunal Act 1998* any such answer or document is not admissible in evidence in any criminal proceedings, other than in proceedings in respect of the falsity of the answer.

Judge Jenkins **Vice President**	**Dr Brian Collopy** **Member**	**Dr Patricia Molloy** **Member**

APPEARANCES:

For Applicant — Mr J. Noonan QC with Ms R Ellyard of Counsel

For Respondent — Ms A Magee QC with Mr P Cadman of Counsel

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REASONS

NATURE OF APPLICATION

1 On 1 March 2016, Dr Rodney Syme applied to the Victorian Civil and Administrative Tribunal (**Tribunal**) for review[1] of a decision (**Decision**) of the Medical Board of Australia (**Board**), to impose a condition on Dr Syme's registration as a medical practitioner (**Condition**), as a form of immediate action pursuant to s 156 of the *Health Practitioner Regulation National Law (Victoria) Act 2009* (**National Law**).

2 The Condition imposed by the Board is as follows:

> Dr Rodney Syme [MED0000944514] is not to engage in the provision of any form of medical care, or any professional conduct in his capacity as a medical practitioner that has the primary purpose of ending a person's life.

3 In his application to the Tribunal, Dr Syme claimed that the Decision of the Board to impose the Condition was wrong, both in relation to the facts on which the Decision was made and the interpretation and construction of s 156 of the National Law; and alternatively the Condition was ambiguous.

SYNOPSIS

4 This application for review of the Decision of the Board requires the Tribunal to determine whether there was sufficient evidence before the Board, through its Immediate Action Committee, to form a reasonable belief that the conduct of Dr Syme posed a serious risk to persons and as a consequence immediate action was warranted, in the form of the imposition of the Condition, to protect public health or safety.

5 It is not the role of the Tribunal in this application for review:

(a) to determine acceptable standards of medical practice with respect to physician assisted death; or

(b) to determine what is or is not legal in relation to end-of-life medication; or

(c) to make any determination as to whether the conduct of Dr Syme constitutes professional misconduct or unprofessional conduct.

6 Nevertheless, evidence was led before the Tribunal which did deal with these issues, to some extent, and thereby provided relevant context.

7 While these Reasons set out a summary of the evidence, the Tribunal has had regard to all of the evidence presented in reaching its determination.

8 The Tribunal is not satisfied that the evidence before the Board supported a reasonable belief that Dr Syme posed a serious risk to persons generally or his patient Mr Erica in particular. Furthermore, the Tribunal is not satisfied that it was necessary for the Board to take immediate action to protect public health or safety. The Tribunal, for reasons more fully set out below, will set aside the Decision of the Board. The Tribunal is comfortably satisfied that the Decision of the Board does not satisfy the terms of s 156 of the National Law by reason that:

[1] Tab 1 to s 49 Statement filed by the Respondent.

(a) There is no evidence to support a reasonable belief that, because of his conduct, performance or health, Dr Syme poses a serious risk to persons generally or Mr Erica in particular; and

(b) Further or alternatively, it was not necessary to take immediate action to protect public health or safety; and

(c) Further or alternatively, the Condition is objectionable and not a valid condition to impose upon one practitioner alone, to the extent that its purpose and effect is merely to restate the law; and

(d) Further or alternatively, the Condition is oppressive, unworkable and uncertain as to its precise terms, operation and enforcement.

BACKGROUND

9 Dr Syme is currently registered as a Medical Practitioner with general and specialist registration. He was first registered on 21 December 1959.[2]

10 On 27 January 2016, the Board received a mandatory notification from the notifier stating that his patient, Mr Bernard Erica, who is terminally ill with cancer, had disclosed to the notifier that Dr Syme is to assist the patient end his life.[3] Further details were provided to the Board by telephone on 28 January 2016.[4]

11 The Board has delegated its decision-making power, in relation to the taking of immediate action with respect to a health practitioner's registration, to the Immediate Action Committee (**IAC**). Actions taken by the IAC are, for all practical purposes, to be regarded as having been taken by the Board.

12 By letter dated 28 January 2016,[5] the Board invited Dr Syme to make a submission about proposed immediate action. In its letter, the Board advised Dr Syme of the reasons why it proposed to take immediate action by imposing the following Condition on his registration:

> *Dr Rodney Syme [MED0000944514] is not to engage in the provision of any form of medical care, or any professional conduct in his capacity as a medical practitioner that has the primary purpose of ending a person's life.*
>
> The Board is proposing to take this action because it reasonably believes that because of your alleged conduct, you pose a serious risk to persons and it is necessary to take immediate action to protect public health or safety for the following reasons:
>
> a. Information has been received on 27 January 2015 by telephone from Mr Bernard Erica's general practitioner… that you intend to assist Mr Erica to end his life.

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2 Tab A s 49 Statement, TB 5.

3 Tab 7 s 49 Statement: file note dated 27 January 2016 of telephone conversation between notifier and Board staff member.

4 Tab 8 s 49 Statement: file note dated 28 January 2016 of telephone conversation between notifier and Board staff member.

5 Tab 4 s 49 Statement: letter dated 28 January 2016.

b. It is considered that any action by a medical practitioner (anticipated or otherwise) that has the primary intent and effect of bringing about the end of a person's life constitutes a significant departure from accepted professional standards and presents a serious risk to that person, such that immediate action is required.

c. Further, it is relevant that any action that results in the intentional death of a person may be a possible criminal offence. In view of this, the Committee noted that the notification suggested that you, in your capacity as a medical practitioner, may be about to engage in conduct that has the primary intent and effect of ending a person's life.

13 On or about 30 January 2016, the Board received a statement from Mr Erica[6] which included:

> I certainly am not at any risk from Dr Syme - in fact, quite the contrary.

14 On 2 February 2016, Dr Syme provided a written submission to the IAC[7] which included:

> It is not open to the Board to form a reasonable belief that Dr Syme, practising in the limited and carefully managed way in which he does, poses a serious risk either to Mr Erica or any other person.

15 On 4 February 2016, Dr Syme attended a meeting before the IAC together with his solicitors, and Ms Ellyard of Counsel. Ms Ellyard made oral submissions on behalf of Dr Syme at this meeting and provided copies of two emails from persons who had made prior contact with Dr Syme.[8]

16 On 5 February 2016, the Board notified Dr Syme of its decision to impose a condition on Dr Syme's registration, in the terms set out above, together with the following reasons for the Board's Decision:[9]

> On the basis of the evidence before it, the Board reasonably believes that because of his conduct, Dr Syme poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety for the following reasons:
>
> a. As identified in the Notice, the Board's concerns arose from information received that Dr Syme intended to assist a patient (Mr Bernard Erica) to end his life.
>
> b. The Board considers that any action by a medical practitioner (anticipated or otherwise) that has the primary intent and effect of bringing about the end of a person's life constitutes a significant departure from accepted professional standards and presents a serious risk to that person, such that immediate action is required.
>
> c. During his verbal submissions, Dr Syme told the Board (among other things) that:

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6 Tab 11 s 49 statement: statement of Bernard Erica to the Board dated 30 January 2016.

7 Tab 13 s 49 statement: written submissions of Dr Syme to Immediate Action Committee dated 2 February 2016.

8 Tab 14 s 49 statement.

9 Tab 3 s 49 statement: letter dated 5 February 2016 from the Board to Dr Syme's solicitors.

i. He has told Mr Erica that if he sought to end his life he would help him. Dr Syme would do this by giving him medication (Nembutal) which he could take by mouth to end his life.

ii. Dr Syme submitted that Mr Erica may choose never to take this medication and it was not his intention that Mr Erica take it. Dr Syme clarified that his intention was to provide relief to Mr Erica from the psychological distress associated with the loss of control over how his life might end and that Dr Syme considered that the mere act of providing the Nembutal would provide this relief. Dr Syme further clarified that Mr Erica may never ask for Nembutal and he may never have to give it.

d. The Board considered the material currently available, including Dr Syme's submissions, and formed a view that Dr Syme's conduct presents a serious risk to persons.

More particularly, The Board formed the belief that providing Nembutal to a patient (in the circumstances Dr Syme described to the Board) has the primary purpose of enabling the patient to use the Nembutal to end their life (irrespective of whether the patient subsequently chooses to take the Nembutal).

e. The Board also formed the view that there are serious risks posed by Dr Syme's conduct in providing medical care to a terminally ill patient (in the manner he described to the Board) that does not include consultation and communication with the rest of a patient's team of treating practitioners.

17 On 16 February 2016, the Board notified Dr Syme of its decision to investigate the notification.[10]

18 On 9 March 2016, the Board received another written statement from Mr Erica[11] which included:

> My quality of life has plummeted since you have imposed those restrictions on Dr Syme.

19 The applicable legislation and relevant case law was essentially agreed between the parties and the Tribunal draws upon the helpful written submissions made by each Counsel, by way of summary.

RELEVANT LEGISLATION

National Law

20 The legislation relevant to the Board's Decision is the **National Law**.[12] Set out below are the relevant provisions of the National Law in relation to immediate action.

21 Division 7 (Immediate Action) of the National Law provides, so far as it is relevant to this application:

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10 Tab 16 s 49 statement: letter dated 16 February 2016 from the Board to Dr Syme's solicitors.

11 Tab 3 s 49 statement: statement dated 4 March 2016 from Mr Erica to the Chairman Immediate Action Committee.

12 Current version no. 5 incorporating amendments as at 17 September 2014.

155 Definition

In this Division—

immediate action, in relation to a registered health practitioner or student, means—

(a) the suspension, or imposition of a condition on, the health practitioner's or student's registration; or

…

156 Power to take immediate action

(1) A National Board may take immediate action in relation to a registered health practitioner or student registered by the Board if—

(a) the National Board reasonably believes that—

(i) because of the registered health practitioner's conduct, performance or health, the practitioner poses a serious risk to persons; and

(ii) it is necessary to take immediate action to protect public health or safety;

(2) However, the National Board may take immediate action that consists of suspending, or imposing a condition on, the health practitioner's or student's registration only if the Board has complied with section 157.

22 In summary, s 156 gives the Board a broad discretion to take one or more of the actions specified in s 155 in order to protect public health or safety. The intent of the section is to provide a mechanism for urgent action, to protect public health or safety, while investigation and/or performance assessment of the relevant medical practitioner are conducted.

23 In exercising its discretion under s 156, the Board is further guided by the objectives and principles of the National Law, as set out in s 3.

24 Section 3(2)(a) provides that an objective of the National Law is:

> To provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

25 Section 3(3)(c) states that a guiding principle of the National Law is:

> Restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

26 If the Board proposes to take immediate action, then it must notify and give the relevant practitioner the opportunity to make a submission.[13] Immediately after deciding to take immediate action, the Board must give written notice to the practitioner of its decision and any further action which it proposes to take.[14]

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13 Section 157 of the National Law.

14 Section 158 of the National Law.

27 A practitioner subject to the immediate action decision may then appeal against the decision to the Tribunal.[15]

28 Section 202 of the National Law provides:

> **202 Decision**
>
> (1) After hearing the matter, the responsible tribunal may—
>
> (a) confirm the appellable decision; or
>
> (b) amend the appellable decision; or
>
> (c) substitute another decision for the appellable decision.
>
> (2) In substituting another decision for the appellable decision, the responsible tribunal has the same powers as the entity that made the appellable decision.

RELEVANT CASE LAW

29 Following is a brief summation of a number of cases to which the Tribunal was referred, relevant to the operation of the immediate action procedure.

30 In *Kozanoglu v Pharmacy Board of Australia*[16] the Victorian Court of Appeal considered the nature of an application for review of an IAC decision. The Court determined that an application for review of an IAC decision is neither an appeal in the strict sense, nor a hearing de novo in the fullest sense of that term.[17] Rather, it is a hybrid in which the role of the Tribunal is to determine whether the decision of the IAC was justifiable on the merits, on the basis of the evidence available at the time the decision was made or evidence that bears upon the position at that time.[18] By definition a decision of the IAC must be made immediately, on the basis of limited material, to decide whether to impose temporary sanctions regarding conduct that is intended to be the subject of further review.[19]

31 The power to act under s156(1)(a) is enlivened where the Board (or the Tribunal on review) 'reasonably believes' that a registered health practitioner's conduct, performance or health poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety.

32 The analysis to be undertaken when looking at the 'reasonable belief' requirement in s.156(1)(a) was considered by the Court of Appeal of the Supreme Court of Western Australia in *Bernadt v Medical Board of Australia*.[20]

33 In Bernadt[21] the Court said there were three components:

- Because of the practitioner's conduct, performance or health ('the factual substratum')

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15 Section 199 of the National Law.
16 (2012) 36 VR 656.
17 Ibid at [119] and [106].
18 Ibid at [108] and [119].
19 Ibid at [109] and 126].
20 [2013] WASCA 259.
21 Ibid at [65]-[68].

- the practitioner poses a serious risk to persons ('the first evaluative assessment') and
- it is necessary to take immediate action to protect public health or safety ('the second evaluative assessment').

34 The facts do not need to be proved on the balance of probabilities but there must be proven objective circumstances sufficient to justify the belief.

35 In *WD v Medical Board of Australia*[22] Horneman-Wren J Deputy President of the Queensland Civil and Administrative Tribunal (QCAT) summarized the approach generally relevant to the merits of an IAC decision as follows:

> 1. an immediate action order does not entail a detailed enquiry;
> 2. it requires action on an urgent basis because of the need to protect public health and safety;
> 3. the taking of immediate action does not require proof of the conduct; but rather whether there is a reasonable belief that the registrant poses a serious risk;
> 4. an immediate action order might be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;
> 5. the mere fact and seriousness of the charges, supported by the untested statements of witnesses, in a particular case, might well be sufficient to create the necessary reasonable belief as to the existence of risk;
> 6. the material available should be carefully scrutinised in order to determine the weight to be attached to it;
> 7. a complaint that is trivial or misconceived on its face will clearly not be given weight;
> 8. the nature of the allegations will be highly relevant to the issue of whether the order is justified.

36 In *Oglesby v Nursing & Midwifery Board of Australia*[23] Horneman-Wren J elaborated as follows:

> [20]…I am not of the view that it is necessary to be satisfied that certain conduct will be engaged in by a registered health practitioner before the reasonable belief can be held that the practitioner poses a risk to persons. In my view, it is not even necessary to be satisfied that it is more probable than not that the practitioner will engage in some conduct in the future. **In my view, a reasonable belief may be held that a practitioner poses a serious risk to persons if, based upon evidence of past conduct, there is a real possibility that the practitioner will engage in conduct which could be harmful to persons**. If the possibility of engaging in the conduct was so remote as to be fanciful, or the possible harm trivial, then I would not think that a belief could reasonably be held that the practitioner posed a serious risk to persons.[emphasis added]

37 In the Tribunal's view these cases are uncontroversial and the principles will guide the Tribunal in this application.

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22 [2013] QCAT 614 at [8]. This approach has been adopted and endorsed in *Ord v Nursing & Midwifery Board of Australia* [2014] QCAT 68 at [8]; *Chaudry v Medical Board of Australia (no.2)* [2014] QCAT 288 at [16] and in *MLNO v MBA* [2012] VCAT 1613.

23 [2014] QCAT 701 at [20].

EVIDENCE

The Notification

38 The notification made to the Board is contained in two file notes of telephone conversations with the notifier on 27 and 28 January 2016. Relevant parts of those file notes read as follows:

> 27 January 2016
>
> The notifier is the patient's usual treating general practitioner.
>
> The notifier is concerned the patient, who suffers from end stage squamous cell carcinoma of the tongue with lung metastases has disclosed that Dr Syme is to assist the patient end his life.
>
> The patient is an ex-CEO and has undergone psychiatric assessments and GP thinks he is of sound mind.
>
> The doctor-patient relationship has existed for a period of 20 years.
>
> The patient suffers from squamous cell carcinoma of the tongue with lung metastases and is currently receiving palliative/end of life care (natural death expected to occur within one month).
>
> The notifier is concerned about information provided to him by the patient in relation to Dr Syme providing assistance to end the patient's life.
>
> The notifier is unaware of how or when this event is planned to occur.
>
> 28 January 2016
>
> …
>
> Mr Erica told him that he wanted information/assistance to end his life. Notifier told him that he could not help him but could provide palliative care. Mr Erica later told him that he had approached Dr Syme in his capacity as an advocate for voluntary euthanasia to ask how he might go about ending his life.
>
> Notifier informed that "they are talking about Nembutal" but he does not have any details of how exactly Mr Erica intends to take his life, when he plans on doing this or what role Dr Syme has or will play.
>
> Mr Erica told Notifier that he had also contacted ABC Television and is currently in the process of making a documentary for Australian Story. Notifier spoke to Mr Erica yesterday and understands that filming for this documentary is currently ongoing…
>
> He continues to provide medical care (including palliative care) to Mr Erica. As far as he is aware, Dr Syme is not directly providing any medical care to Mr Erica.
>
> …

Dr Rodney Syme

39 Dr Syme gave oral evidence before the Tribunal; and also relied upon the submission dated 2 February 2016, made on his behalf to the IAC; and a further statement dated 28 April 2016.

40 Dr Syme graduated in medicine in 1959 and following further postgraduate studies qualified as a specialist in Urology in 1968. He has no specific additional qualifications in counselling, psychology or psychiatry. He has continued to practice as a Consultant Urologist since that time at the Austin Hospital and Repatriation General Hospital; and was later head of a combined Urological Unit for both hospitals. He ceased operating actively in about 2008 and continued to see patients clinically until the beginning of 2016 as well as providing medico-legal urology reports.[24]

41 While in charge of the spinal injury service at the Austin Hospital he was typically treating young male trauma victims who suffered paralysis and erectile dysfunction, with consequent severe psychological trauma. In treating these patients he developed counselling skills beyond the experience and expertise of most Urologists.

Applicant's submission to IAC dated 2 February 2016

42 Dr Syme submitted that he does not engage in, or proposes to engage in, any conduct which poses a serious risk to any person and which would render it necessary to take immediate action.[25]

43 Dr Syme acknowledged that the boundaries of appropriate medical care to terminally ill patients is a controversial issue in society and a vexed question for many practitioners. In consequence:

> … Many patients do not receive the support they seek from their doctors because of concerns about whether the support can properly be given. In being open about the advice and support he offers to patients, Dr Syme hopes to improve both the circumstances in which the terminally ill can be cared for and the context in which medical practitioners are called upon to provide that care.[26]

44 Reference is made to clause 1.4(c) of the AMA Code of Ethics which obliges doctors to respect the right of a severely and terminally ill patient to receive treatment for pain and suffering, even when such therapy may shorten a patient's life: [27]

> It is widely accepted in palliative medicine that, consistent with this clause, doses of medicine may be given to patients to relieve their pain and suffering even though it is foreseeable and indeed inevitable that those doses will also have the effect of hastening the patient's death. The use of morphine and sedatives for this purpose is widely accepted and meets the needs of many patients. However, not all patients wish to receive that form of palliative care because of the loss of dignity, control and comfort which can be associated with it.
>
> Dr Syme's practice is a form of palliative care that is directed to the palliation of the psychological and emotional suffering experienced by some patients in the end stages of terminal disease. In particular, a sense of having control over the end of one's life is one of the most powerful tools for the relief of that psychological and existential suffering.
>
> Dr Syme's practice therefore is directed to providing support, including information and advice, which gives that sense of control to patients. It should be noted that that support

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24 Statement dated 28 April 2016 [1]-[2], TB 54; and oral evidence.
25 Statement 2 February 2016 [5], TB 42.
26 Ibid [9], TB 43.
27 Ibid [11]-[14], TB 43.

frequently results in patients being reassured that their needs will be met by traditional palliative care.

45 Dr Syme denies that he has any intention to assist Mr Erica to end his own life or that he has or proposes to take any action with that intention. Dr Syme acknowledges that he agreed to meet Mr Erica after being contacted by him. In conversations with Mr Erica, Dr Syme provided advice and information which included the topic of Mr Erica having control of the circumstances of his death:[28]

> Mr Erica sought that control so that he could spend his final weeks in a calm and peaceful manner without fear and distress about the future.
>
> …
>
> The provision of advice and assistance which has the sole intention of relieving psychological suffering is properly to be seen as a legitimate form of palliative care. Dr Syme does not intend Mr Erica to end his life though he recognises that there are circumstances in which Mr Erica might choose to do so. His care of Mr Erica is directed not to the ending of Mr Erica's life but to the improvement of the quality of Mr Erica's life.

46 Dr Syme's position is concisely summarised in his submission as follows:

> Dr Syme's practice is limited to advising and assisting patients who are in the final stages of terminal illness and to whom a sense of control over their dying is important. His patients seek him out. He does not advertise for patients. He therefore has contact only with those patients who self-identify as being part of a cohort for whom traditional palliative care options may not be acceptable. Having been contacted by them, he assists only those whom he is satisfied are in a sound state of mind and whose death from their disease is inevitable or whose disease has progressed to the extent that their lives have become intolerable to them.[29]

47 The submission to the IAC concludes as follows:[30]

> It is not open to the Board to form a reasonable belief that Dr Syme, practising in the limited and carefully managed way in which he does, poses a serious threat either to Mr Erica or to any other person.
>
> Dr Syme's position and practice in relation to the rights and needs of terminally ill patients is a matter of public record. His work has been brought to the Board's attention on at least two previous occasions. On those two occasions, despite the availability of considerably more information than is available here, the IAC was never convened and the Board ultimately determined that no action of any kind was required.
>
> The present notification does not give rise to the need for any immediate action.

Dr Syme's Statement dated 28 April 2016

48 In about 1974, Dr Syme was profoundly affected by his contact with a patient with spinal cancer, who was suffering severe neuropathic pain, which no medicine at the time could relieve. Since that time he has made a particular study and closely followed

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28 Ibid [17], [19], TB 44.
29 Ibid [21], TB 44.
30 Ibid [26]-[28], TB 45.

the medical literature dealing with palliative care and end-of-life matters. His experience and the literature strongly support the proposition that end-of-life control to patients has a profound palliative effect.[31]

49 Dr Syme has counselled persons about their end of life wishes since 1974 and particularly in the last 20 years. Since about 1990, he started to be contacted by people who did not have urological problems, but had end-of-life problems due to other kinds of cancer. These patients could get either no or inadequate satisfaction from their treating clinicians in addressing their end-of-life questions and problems.[32] In his statement and in oral evidence Dr Syme emphasised that the people who contacted him were particularly appreciative of having somebody they could talk to, who would listen and understand their problems. Many were just fearful of the future; many had currently a diagnosis of cancer, which appeared to be under control, but were worried about what might happen. Many would not need to contact him again, but knew he was available 'if things go badly for them.'[33]

50 Dr Syme categorised the patients who have contacted him into more than seven groups according to the nature of their disease and/or assistance sought:[34]

> While the range of people seeking assistance is very broad, the number of people to whom I give actual assistance (medication, including amylobarbital, Nembutal and opioids) is very small, largely confined to those with cancer in the terminal phase and those with the severe neurological illness, particularly in motor neurone disease. I have provided medication to around 10% of the approximately 1700 patients whom I have counselled.[35]

51 During consultations with these patients, Dr Syme will: [36]

(a) obtain a detailed history encompassing: their personal details; social, family and medical history; their current condition/s causing concern;

(b) ask about their treating medical practitioners; and their treatment;

(c) ask the patient to obtain documentary evidence from their treating clinicians, such as full clinical statements or hospital records, if he is not confident from his own clinical assessment as to the patient's condition and circumstances;

(d) assess their mental competency and rationality;

(e) assess their actual suffering: physical, psychological and existential;

(f) recommend appropriate psychiatric or psychological assessment, if there is any concern about the patient's psychological health and he will refuse to give any further assistance at that time; and

(g) recommend and encourage them to speak to their treating doctor/s or obtain a second opinion, if it is clear to him that the patient might have further treatment options, including pain relief.

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31 Statement [3]-[6], TB 54.
32 Ibid [7]-[8], TB 55.
33 Ibid [25], TB 57.
34 Ibid [11]-[[21], TB 55-56.
35 Ibid [22], TB 56.
36 Ibid [26]-[33], TB 57-58.

52 In his oral evidence, Dr Syme emphasised to the effect that he did not and did not seek to replace the patient's treating doctors. The advice and counselling which he provided, was sought by these patients because they simply could not get such support from their existing medical team, for their particular fears and/or intolerable suffering.

53 Dr Syme described most of the people who contacted him as having physical suffering, usually severe; they know they are dying and that the suffering will continue and likely get worse. In this context Dr Syme described:[37]

> … extra ordinary and often unrecognised psychological distress, extreme anxiety, fear, even terror as to what is going to happen to them.
>
> Commonly there is what I call "existential suffering" and this involves all sorts of losses relating to quality of life, the sense of being a burden, the sense of not having control, the sense of having no purpose in life, loss of social contact and intimacy. All of these phenomena are existential losses, relating to the circumstances that these people find themselves in…
>
> … You can, I think, influence the psychological suffering quite significantly by engaging with the person, showing empathy and compassion with their problems, listening to them, talking to them and ultimately if you see that they are on a significantly progressive downward path, giving them medication will have a profound psychological impact, a positive impact.
>
> Giving them control alters their psychological thinking entirely, and it can have a profound effect on physical symptoms as well. All the physical symptoms we actually have are experienced in the mind. And if we change the way a person is thinking, you can often diminish a lot of physical symptoms. You cannot change weight loss or weakness but you can influence pain, you can influence breathing, you can in fact psychologically induce more energy in a person.

54 In his Statement[38] and oral evidence, Dr Syme also emphasised the importance of involving the patient's family, where possible. Sometimes he is first approached by a family member but will always insist upon also speaking to the patient personally. When asked the question 'what do you want to do?' the patient will often say 'I want to have the option to end my life.'[39]

55 Two emails were provided as examples of the range of circumstances affecting patients who contact Dr Syme. In one case, a grandchild of a patient thanked Dr Syme following a telephone consultation with the patient which caused her to seek further medical attention, to significant advantage; and a second case where a male now in his mid-40s, thanked Dr Syme for having declined to help him, when he was suicidal and was subsequently greatly assisted by medical and psychiatric care.[40]

56 In relation to the small group of people to whom he has provided medication, Dr Syme describes his staged approach as follows:[41]

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37 Ibid [40]-[43], TB 59-60.
38 Ibid [35], TB 58.
39 Ibid [34], TB 58.
40 TB 46-47.
41 Ibid [44]-[48], TB 60-61.

I usually do not provide medication straightaway, even to those whom I think may ultimately want the opportunity to have and use it. Rather, I, in appropriate cases, give an undertaking to a person that at an appropriate time I will give it to them.

The promise of medication has an effect, provided they believe you. One of the standard responses of doctors to patients who worry about their future is "do not worry, we will not let you suffer" which nine times out of 10 is a promise that is not kept… The promise of assistance, unless it is firmly believed, is of little value.

If it is believed, it can be of value. If at the time you first see them and talk with them they clearly show that they want control, but they are not actually at a point where they might be going to exercise or use that control, then supporting them, maintaining a dialogue, giving them a promise of support, is often all they need to palliate their suffering. They do not need medication at that point.

Later, as their disease or symptoms progress, the time comes when only actually having the medication in their possession gives the sense of control that is needed to palliate their psychological suffering. Palliative care recognises what is called a "total pain syndrome", that is the term they use and it encompasses not only physical but psychological, and they call it "spiritual pain", but I use the term existential, but it is the broader aspect of total suffering. It is a matter of judgement as to when is the correct time as to when to provide it. I do not think you get the benefit from providing it if you leave it until the very last minute. Notwithstanding my usual approach referred to earlier, there is a small number of persons in the terminal stage of a terminal illness whose suffering is refractory, and so severe that I provide the Nembutal at the first consultation, because there is no time for further dialogue. Prior to doing so, I make appropriate and relevant inquiries regarding the patient's medical status. The emphasis is on the necessity to relieve intolerable suffering-either by terminal sedation in palliative care (which they emphatically reject) or by taking control of the end of their own lives with Nembutal.

I want to provide these people with the psychological benefit of control. I want to diminish or eliminate the psychological distress which they have, which then improves the quality of life. They feel, "I am in control now". And that is what I think, they should be in control of their death, make their own decisions, not the doctor.

57 Dr Syme describes his purpose and intention in assisting patients as follows:[42]

If you give a person Nembutal, a drug which can end their life, then of course they might use it and I can foresee of course that they might do that.

When I first started doing this, I did feel my intention was to allow a person to end their life. But as time has gone on, I have recognised very, very strongly the palliative value in having the medication without using it. It first became apparent to me with a woman who had a brain tumour, whom I gave medication to and she survived for another three or four years. I was in constant contact with her during that time and eventually she did not use it and died naturally.

It made me realise that having the medication in her possession had just had a powerful value to her, increasing her quality of life. That was self-evident. Although she wanted that control and it gave her that control, it did not mean that she ended her life at that

[42] Statement [49]-[56], TB 61-62.

point. It just strengthened my experience in that most people would hang on to life as long as they possibly can, they will not use this medication without deep consideration. And ultimately she did not use it, which made me realise again that giving a person medication was not done by me because I wanted or intended them to use it.

I can say that categorically, that my intention is to give a sense of control and by so doing to ease their suffering. It may also be the case that yes, the person could use this drug to end their life, but by the time I make the assessment that they need to have possession of the medication I am confident that they will not do that unless they feel it absolutely necessary to use it.

To me, I see quite a direct analogy with palliative care, which treats people in similar circumstances to those people to whom I provide medication. They provide medication by subcutaneous injection, which has the effect of relieving the suffering by putting a person into a coma, slowly, but they stay in the coma until they die. They argue that it is okay because they say it is not their *intention* to hasten death, but it does hasten death, and arguably more or less in some cases.

I apply the same argument to what I do, in that I give people medication which they may take orally, not by injection. They may take it orally. They can control the process, not the doctors controlling the terminal sedation process. And in both instances, the argument that the intention is to relieve the suffering applies, in both instances one can foresee that the provision of that treatment may hasten death, so there is a very strong parallel between the two.

Many of these patients will find that with support through the medication being in their possession, they can go on with their lives and die naturally, with traditional palliative care or other treatment being sufficient for them.

Although I have not kept statistics, I believe that about 10 to 15% of the people to whom I give Nembutal do not use it and I ask them to give it back to me, because although it has no intrinsic monetary value, for other people it has extraordinary value for people who may need it.

Bernard Erica

58 In his Statement, Dr Syme gives a comprehensive summary of his consultations with Mr Erica who first contacted him on 10 November 2015, after seeing Dr Syme on the Q&A television program.

59 Mr Erica suffered tongue and throat cancer and most recently multiple metastatic lung nodules. He had been treated with radiation and chemotherapy. He suffered significant throat pain, particularly on swallowing, loss of energy, loss of appetite and loss of weight. He was very anxious about his future and was not satisfied with the care offered to him by his general practitioner. When he first saw Dr Syme his primary concern was to have control over his end-of-life. He had previously unsuccessfully attempted to obtain Nembutal. Mr Erica was a retired CEO of a major Japanese company in Australia.

60 At his first consultation, as well as obtaining a detailed personal and professional history, Dr Syme assessed Mr Erica in terms of his personality; his state of mind; his ability to understand questions asked; and his competence and capacity and understanding of his psychological state. Dr Syme then obtained details about his prior

medical history; how his disease developed, his initial and current symptoms and treatment; his relationship with his treating medical practitioners, including his GP and specialists at the Peter McCallum Clinic; and his knowledge and understanding of palliative care.[43]

61 Dr Syme initially assessed that Mr Erica would likely survive only two or three months, although he had not seen his scans.

> I determined after considering his history, general appearance and my experience, that this was a man who would benefit from having a commitment from me to providing him with support including a commitment to provide him with Nembutal in the event that it became necessary. I did not accept that he needed it at that particular moment. It was the first time I met him, that I was committing to support him, and as I have found with others, I believe that had a beneficial effect on him. I observed that he was very relieved to have the support that he believed was in his best interests.[44]

62 Mr Erica again conferred with Dr Syme on 23 December 2015, by which time his condition had deteriorated, including a residual radiation induced ulcer and/or malignant ulcer in his throat.

> I reaffirmed my support to him, by which I mean I gave him an undertaking that I would provide him with Nembutal, at the appropriate time. I gave that undertaking to improve his quality of life. I believe I did improve his quality of life:
>
> 1. The improvement I observed in his psychological state. He reported diminished anxiety and subsequently reported increased appetite and energy. This was occurring while he received no other treatment except for pain relief and his metastatic disease was increasing.
> 2. He recently appeared with me at a Monash medical student conference (Torque-on end-of-life issues) in which he was on a panel and was actively involved in trying to help the students understand the issues.[45]

63 Dr Syme subsequently conferred with Mr Erica by telephone on 13 January 2016 and in person on 30 January 2016. Mr Erica had suffered further weight loss but had been trialled with a pain relieving injection and was due to receive a nerve blocking procedure.

> He told me he was very angry with his general practitioner, who had reported me to AHPRA.

64 Dr Syme spoke to Mr Erica again on 10 February and saw him on 25 February 2016. Dr Syme recommended that he take his sedative medication earlier, which subsequently improved his sleeping. However, Mr Erica continued to lose weight and his energy was diminishing. Mr Erica had spoken to his general practitioner about palliative care and was not comforted by the advice received as to medication he could be given to take at home. Mr Erica advised that he was seeking an alternative source of Nembutal, which he subsequently obtained.[46]

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43 Evidence in Chief.
44 Ibid [61], TB 10.
45 Ibid [62], TB 63.
46 Ibid [64]-[65], TB 64.

One of the things that often happens as a result of giving a person support is that, by changing their psychological state, you can actually give them purpose for continuing to live. If you have no purpose in life, you go downhill very quickly. If you have a purpose, you keep driving on. I think it has had an existential benefit for Bernard.[47]

65 In relation to the question of his conferring with a patient's treating medical practitioners, Dr Syme explained that, although desirable, this was not always possible. While in some cases patients are referred to him by professionals who are not themselves comfortable to deal with the issues raised by the patient, mostly the patients contact him, irrespective of the treating doctor.[48]

> In my experience there are two likely outcomes if you contact the treating doctor or if the patient themselves tells their doctor that they have contacted me:
>
> 1. They contact mental health services about their patient, saying they are suicidal (I have had patients sectioned by the CAT team, though once at hospital they were found entirely well by the assessing psychiatrist)
> 2. They threatened to report me to the Medical Board of Australia or to the police, perhaps because they are worried about what will happen to their own medical registration if they do not.
>
> It is very problematic, because involving the treating doctor may have an adverse effect on the patient and how they are treated by their treating doctor. Also, when you put yourself in the treating doctor's position, if I approached them and say this is what is taking place, they are in a way becoming complicit in the process - a process which the vast majority of doctors would think is a murky area. The law is not transparent in these matters, the law gives no protection to doctors. I am confident for myself that what I am doing is legal but I do not think I have the right to force other doctors to hold the same view.
>
> As I have said, I do always take steps to ensure I have information about a person's treatment and prognosis.

66 In conclusion, Dr Syme commented upon the impact of the Condition:

> The condition… has caused a lot of uncertainty for me about the limits on what I can do for those who contact me for assistance or advice…. I am very clear in my own mind that what I do, including the provision of medication in some cases, is done for the purpose and with the intention of palliating suffering and improving quality of life. So on that basis the condition does not affect what I do because I do not have the primary purpose of ending a life. But at the same time I am aware the Board imposed a condition because it has a different view of what I do and of my purpose.
>
> A really large number of people I do see and talk with, I just talk with once, maybe twice, and I do not provide them with any other assistance at all… I think that just talking has an enormous benefit for them. The condition does not prevent me from having those discussions. However, I think that part of the value of the conversations I have is that people know that, in certain circumstances, I can do more than talk. If it was

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[47] Ibid [66], TB 64.
[48] Ibid [67]-[71], TB 64.

known that I could not provide assistance beyond talking it would certainly diminish the value of the conversations for those people.[49]

67 In his oral evidence, Dr Syme said that Mr Erica was determined to get control over his end of life, not be a burden on others and not be subject to hospitalised palliative care or relying upon such medication as he could be given, to take it at home. He had already unsuccessfully sought Nembutal directly and that is why he initially made contact with Dr Syme.

68 Dr Syme agreed that the compilation of handwritten notes, which Dr Syme had made from time to time during consultations with Mr Erica, did not contain details of his clinical examination and assessment of Mr Erica's psychological improvement and existential well-being. However, he is well experienced to make such observations and assessment and he observed a very significant positive impact upon Mr Erica, following the giving of an undertaking at his first consultation. Mr Erica also expressed that his energy level had 'markedly increased' and in participating in a conference convened by Monash University, he demonstrated a renewed purpose in his life.[50]

69 Dr Syme has never charged Mr Erica and in relation to other patients, charges are made only if they make appointments to see him at his office, in which case he will recover the Medicare benefit only.

Cross Examination of Dr Syme

70 In summary:

(a) Dr Syme agreed that certain barbiturates, including Nembutal, cannot be prescribed or legally obtained, by a medical practitioner and that it is probably illegal to give Nembutal to another person;

(b) Dr Syme said that the law is very unclear in the area of terminal palliative care and leaves many medical practitioners uncertain as to what they can do;

(c) Dr Syme confirmed that the use of opioids, the primary purpose and effect of which is to relieve pain, can be a dangerous and uncertain method of ending one's life, including that a patient may survive in a brain damaged state;

(d) Dr Syme also confirmed that when he gives an undertaking to provide Nembutal, he intends to honour such undertaking, provided however that appropriate circumstances exist at the relevant time, such that he can assess that the patient's significant psychological and existential suffering will be palliated. When he gives possession of Nembutal, he will also give instructions as to its use. He clearly contemplates that there is a possibility they will take it; however, as indicated in the article appearing in the Age newspaper[51] concerning his patient Ray Godbold, upon giving such explanation as to how to ingest the drug and what effect it will have, he will typically tell his patient that it is not his intention that they in fact take it and it is his hope that they will not need to take it;

(e) Dr Syme has counselled approximately 1700 patients over the years in relation to end-of-life care, of whom only approximately 10% have been given Nembutal.

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49 Ibid [77]-[78], TB 65-66.

50 Evidence in Chief.

51 Exhibit B.

Although he does not have accurate figures he estimates that approximately 40% of this group may have actually taken the drug, but the time within which they choose to do so has varied between two weeks and three years after gaining possession;

(f) Dr Syme agreed that he does not keep written records of:

i. the psychological or mental condition of his patients, including Mr Erica;

ii. any changes in the psychological or mental condition of his patients, including Mr Erica;

iii. whether he has provided a patient with Nembutal, or an undertaking to provide Nembutal; or

iv. any changes in a patient's psychological or mental condition due to the promise or supply of Nembutal;

(g) However, in relation to written records, he alluded to the fact that the current state of the law effectively precludes comprehensive record keeping concerning Nembutal. In regard to other aspects of record-keeping, he is frequently dealing with patients at the very terminal phase of their life where all treatment, in terms of possible cures or prolongation of life, has been exhausted. He has extensive experience and expertise in taking a history and conducting an adequate clinical examination as well as making appropriate observations over the period during which the patient consults with him. Accordingly, in this context and where he is not otherwise treating any patients, other than by counselling and advice, he maintains that his record-keeping is appropriate and adequate; and

(h) Dr Syme does not receive or seek out information from his patient's other treating health practitioners, except on infrequent occasions when they are supplied by the patient; he does not see patients' diagnostic materials such as scans or reports; and usually does not have any interaction with his patients' other treating practitioners, but relies on self-reporting by his patients. However, as explained in his statement, Dr Syme will confer with the patient's treating practitioners and obtain relevant documentation concerning the patient's diagnosis and treatment, where this is the wish of the patient. The situation can be both complex and delicate and he explains in his statement his desire not to compromise the professional position of treating doctors or breach the confidentiality of the patient.

Bernard Erica

71 Mr Erica had previously made a statement dated 30 January 2016 to be used by Dr Syme in his hearing before the IAC. In this statement, after describing his disease and his realisation that it is incurable and he may well die in the near future, Mr Erica stated as follows:[52]

> In addition I have severe suffering both physical and psychological.
>
> My physical suffering is (1) pain in the throat, which is constant and aggravated by every swallow. I have recently had an anaesthetic procedure in an attempt to minimise

[52] Statement of Bernard Erica dated 30 January 2016, TB 70.

> this; (2) severe loss of appetite and weight and debilitating weakness; (3) increasing breathlessness on exertion.
>
> My psychological suffering relates to my extreme loss of control over my own destiny and my fear of extreme suffering and loss of choice as my disease progresses. I want to die at home surrounded by family and friends. I do not want to be hospitalised under palliative care and die by slow sedation and dehydration.
>
> The suffering I endure relates to the loss of independence, control and purpose in my life.
>
> This suffering lead me to try and source Nembutal from abroad which resulted in extreme stress level and loss of over US$2000.
>
> I saw Dr Syme on Q&A and immediately contacted him. After a prolonged phone conversation, he agreed to see me and we met on 13/11/15. He spent over an hour exploring my history and my values. He agreed to support me and advise me and committed to ensuring that I had control over the end of my life, if or when, my circumstances deteriorated to an intolerable level.
>
> We have remained in close contact since then. The effect of his support and advice has been extremely valuable. None of the other doctors who have attended me have provided such benefit and peace of mind. My psychological suffering has diminished to a large degree. I am calm and accepting of the reality of my situation. Dr Syme's care has had a profound palliative effect.
>
> I agreed to become involved in Australian Story in order to increase the understanding in the community of the issues involved, with the ultimate objective to allow the community to have the choice of voluntary Euthanasia.
>
> This involvement has had significant value in providing a sense of purpose to whatever time I have left.
>
> I certainly am not at any risk from Dr Syme - in fact quite the contrary. I do anticipate that the need to end my life because of extreme suffering may occur, and if it does, I will regard that as a peaceful way to end my life. If I make that decision, it will be after careful and prolonged thought and in a rational state of mind.
>
> I hold Dr Syme in the highest regard and I am saddened that his assistance to me has brought him into conflict with the Medical Board. I cannot understand how the traditional palliative care must be an obligatory treatment for all dying persons, this is contrary to my belief.

72 Following the decision of the IAC, on 4 March 2016, Mr Erica wrote to the Chairman of the IAC in which he stated in part as follows:[53]

> I wish to have control over the end of my life and the ability to end it with dignity and security when I can no longer tolerate my end-of-life symptoms and suffering. My quality of life has plummeted since you have imposed those restrictions upon Dr Syme.
>
> I have enquired of my GP… what palliative care he can provide. He has informed me that he will provide palliative care to me in my home when required with MS Contin, Maxolon for nausea and vomiting and the maximum strength of Ordine. He indicated that I could determine the dose of the Ordine necessary to relieve my pain. My

[53] Statement of Bernard Erica dated 4 March 2016, TB 72-73.

interpretation is that [my GP] is committing, under the umbrella of palliative care, to provide me with sufficient oral medication to end my life but with no advice as to how to proceed, leaving me to contemplate such an end in an uncertain, haphazard manner without any security as to the outcome. This gives me no comfort whatsoever.

…

At the present time, I am extremely fortunate that recent treatment - targeted radiofrequency has diminished my throat pain.

However, I am suffering from a number of symptoms which are either un palliatible or currently resisting palliation. These include:

(a) physical weakness;

(b) severe loss of appetite and loss of weight;

(c) restless heavy legs;

(d) Sleeplessness - medication for such leaves me 'dopey' during the day;

(e) loss of quality of life and of purpose in life;

(f) fear and anxiety about my future;

(g) extreme fatigue after walking 100 m

These symptoms are certain to continue and increase, unpalliated, until my death. They will not be palliated by the medication provided by [my GP] which is for the management of pain. These symptoms will only be relieved if I take a massive overdose of the pain medication provided by [my GP] and this option is entirely unpredictable.

Alternatively, I understand that I could opt for institutional palliative care, where I would be provided with slow terminal sedation with the potential for hastening my death.

How can either [my GP's] palliative care or the institutional palliative care be considered not to have an outcome of ending a person's life and how is a determination made that this is not the primary purpose of the treatment?

How is the palliative care better than the option proposed by Dr Syme and which you are preventing?

73 Mr Erica provided an affidavit dated 28 April 2016, in which he confirms that he is a patient of Dr Syme. In his affidavit, Mr Erica described his dealings with Dr Syme as follows:

Why I contacted Dr Syme

I decided to contact Dr Syme after I made two attempts to access Nembutal from overseas, which failed due to it being a scam. I saw Dr Syme on the ABC program Q&A speaking about euthanasia, so that's what made me decide to contact him.

I contacted him because I hoped he would be able to give me advice on where I could source Nembutal to give me peace of mind.

My views and wishes about the end of my life

> I just want to have complete control over decision making about the future course of my life and the treatment I receive, and certainly don't want to rely on any palliative care or nursing home.
>
> This is important because I am in control and will not be leaving it up to someone in palliative care who does not really understand my pain level or psychological state of mind.
>
> If my views and wishes were not given effect I would be very disgruntled and extremely stressed.
>
> **The assistance Dr Syme has given me**
>
> To date, Dr Syme has provided me with palliative care in terms of verbal counselling. It is far better than that I have received from either psychological advice or from Peter Mac or my local GP. It means that I am in total control. It gave me peace of mind.
>
> There is no comparison whatsoever to the way in which other doctors responded when I raised the question of control over the ending of my life, because both the GP and oncologist just completely avoided the question due to fear of reprisals in the form of losing their license.
>
> As a result of the advice and assistance Dr Syme gave me I became far more relaxed knowing that I would have Nembutal if he were able to supply it to me. It gave me more energy knowing that I am not stressed out by trying to source Nembutal from overseas. Feeling better psychologically has also made me feel better physically.
>
> At the time of the conditions being placed on Dr Syme's registration, I once again became worried about losing control and knowing that I would have to attempt to source Nembutal overseas with the knowledge that it is illegal and could result in heavy fines or a jail sentence. It meant I may have to resort to some other, ugly form of suicide as I refuse to go into palliative care.

74 In his oral evidence Dr Syme confirmed that he had spoken to Mr Erica twice in the previous week. Mr Erica's disease has progressed, but his psychological suffering has been significantly palliated by Dr Syme's support. Mr Erica has also been given a commitment from another source for the supply of Nembutal.

EXPERT EVIDENCE

75 Expert opinions were given by Dr Roger Hunt, on behalf of Dr Syme; and Professor Ian Maddocks, on behalf of the Board. Both experts are eminently qualified and experienced in Palliative Medicine.

Professor Ian Maddocks

76 Prof Maddocks, Emeritus Professor, Flinders University; Consultant in Palliative Medicine; he retired from active practice in 2014. He was appointed foundation Prof of Palliative Care, Flinders University in May 1988; was Foundation President of the Australian Association for Hospice and Palliative Care; and Foundation President of the Australian and New Zealand Society of Palliative Medicine. He has lectured and published extensively, both texts and articles, on palliative care.

77 Prof Maddocks provided a report dated 13 May 2016; a supplementary report dated 22 May 2016; and oral evidence before the Tribunal. In his reports he addressed a series of questions put to him on behalf of the Board. In particular, he describes the current accepted professional standards of palliative care practice in 'end-of-life' situations; the published guidelines in relation to such standards; the rationale and underlying reasons for such standards; the currently accepted clinical practice followed by a medical practitioner who treats patients with terminal illnesses and any relevant additional training; the process of consultation in a palliative care context; the purpose and use of amylobarbital, Nembutal and opioids; whether such drugs fall within generally accepted professional standards and clinical practice; the primary purpose of such medications; and the principle of double effect.

78 In relation to the category of barbiturate drugs, which include amylobarbital, pentobarbital (Nembutal) and phenobarbital:

> They used to be commonly prescribed for sedation and anxiety, but proved to have addictive properties, and because of associated respiratory depression were regarded as dangerous for any persons with respiratory difficulty, as well as proving sufficient, in a high dose, to cause death (from sedation and respiratory depression) by suicide.
>
> Either phenobarbital 10g in a solution, or pentobarbital 9g in capsules are the common medications administered for the purpose of physician assisted suicide (PAD) in those countries where PAD has been introduced. These medications do not appear in the list of approved drugs in Australia (but, I understand, are available in veterinary practice) and are available for human use only from overseas (if not intercepted by Customs as illegal imports).[54]

79 In his supplementary report, Prof Maddocks clarified that the only barbiturate available for prescription in Australia is phenobarbital, which is used for the prevention of seizures in epilepsy.[55]

80 In relation to opioids, they are available in a wide range of formulations, modes of delivery and doses:

> Their prime use is for relief of severe pain, and the dose cannot be anticipated, since, over time either the pain caused may change, tolerance to the drug may increase (requiring higher dosages), or side-effects emerge to cause difficulty and require change to another opioid.
>
> Opioids are not a satisfactory drug class for PAD or suicide because of the wide variation in their effect in one individual. In a naive subject, one who has not taken opioids previously, a single high dose might cause death, but in a person already tolerant, after receiving regular opioids, it is quite difficult to predict what the outcome of ingesting quite a high dose might be.
>
> Opioids have multiple effects. They are used primarily for the relief of pain, but have also been used in the past for relief of diarrhoea. They have many side-effects, including constipation, nausea, confusion and hallucinations and itch. [56]

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54 Expert Report dated 13 May 2016, [18], TB 89.
55 Supplementary Expert Report dated 22 May 2016, TB 97.
56 Ibid, [18], TB 89-90.

81 In relation to whether the category of barbiturates fall within generally accepted professional standards and clinical practice:

> There is no approved use of barbiturates within generally accepted professional standards.[57]
>
> …
>
> There is no opportunity, as far as I am aware, for barbiturate drugs to be prepared outside of the pharmaceutical industry. They are available only illegally and from overseas.[58]

82 In relation to the primary purpose of providing barbiturates and opioids, Prof Maddocks confirmed that currently barbiturates cannot legally be provided by a physician:

> The prime purpose for obtaining them, therefore, will be for the purpose of suicide, or to give a patient the confidence that he or she can arrange to die by their own hand at a time of their choosing… It may be argued that obtaining a 9g dose of Nembutal has the purpose of building an enhanced sense of 'control' for the patient. It will seek to provide an assurance that the drug may be taken at any future time, but possibly never used, and is therefore not providing the drug to cause death. However, there is no other purpose for ingesting the drug and whenever taken, it will cause death.
>
> The primary purpose of opioids is quite different, the relief of severe pain, and not to cause death.[59]

83 In relation to whether there is any role for the assertion that the provision of Nembutal can be for the primary purpose of alleviating psychological suffering:

> Suffering is multifactorial in its origins. In either physical, mental or psychological areas it is notoriously difficult to assess, being closely part of an individual's perceptions of their own experience in life with regard to comfort/discomfort, function/dysfunction, support/isolation and meaning/demoralisation.
>
> I have no doubt that psychological suffering can be so distressing to an individual that he or she will wish to access PAD and have recourse to barbiturates with as much personal urgency as will be experienced by an individual in unrelieved pain. Some persons so affected may seek from suicide the relief that they anticipate. But in either instance, (psychological suffering or severe unrelieved pain), there is a need for careful exploration of the situation and consideration of what might be done to relieve distress in other ways.[60]

84 In relation to the circumstances in which barbiturates and opioids would pose a serious risk to persons, Prof Maddocks noted that s 156 of the National Law refers to 'poses a serious risk' which may be taken to be the risk of 'harmful effect'. However, the meaning of 'harm' is open to interpretation:

> The reason for taking one of the aforementioned drugs will be to bring about the particular 'harm' of death. That death may be regarded by the patient, however, as a 'benefit'. Death is commonly regarded as an ultimate harm, even though inevitable for

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57 Ibid, [18.4] TB 90.
58 Ibid, [18.5] TB 91.
59 Ibid, [19] TB 92.
60 Ibid [20], TB 92.

> all of us, and yet a 'good death' (as intended by Palliative Care support) often has proved a great comfort, whether in anticipation for a patient or in retrospect for an attending family.
>
> Barbiturates will be able to cause that harm/benefit of death in any instance if given in sufficient dose.
>
> Opioids are a quite different category. They have a number of undesirable potential side effects – nausea, constipation, confusion, itchiness - all minor types of 'harm', but as mentioned above, opioids are relatively poor vehicles for causing the particular 'harm' of death.[61]

85 Both Prof Maddocks and Dr Hunt explained the principle of double effect, in essentially the same terms, but expressed quite different perspectives as to its relevance to Dr Syme's conduct. Clearly this is a concept which conceptually and practically raises acute difficulties within the medical profession.

86 Prof Maddocks referred to Dr Hunt's description of the principle of double effect and responded as follows:

> The prescription of deep sedation for severe patient discomfort when it seems the only possible strategy to bring acceptable relief is an accepted approach in Palliative Care and not requiring justification. The term 'double effect' is commonly invoked to describe the distinction between an intended death, which is euthanasia, versus a death that is merely foreseen as a consequent side-effect. Palliative care physicians have needed the protection of legislation that allows them to prescribe medication in doses necessary to relieve suffering, with the assurance that even if the medication is regarded as likely to hasten death (for example through causing diminished consciousness, inability to take nutrition, or respiratory depression) no criminal prosecution will be incurred.
>
> It is a circumstance that raises considerations of both *intention* and *agency* and in ethical discussion, argument can become quite complex. The physician is the agent in causing death, by administering medication, but the prime intention is relief of suffering.
>
> In this regard, the provision of continuous analgesia and sedation by subcutaneous infusion for relief of severe pain that is commonly offered in terminal care does not, in my view constitute 'slow stream euthanasia' as is sometimes implied. Managed with care, while ensuring comfort, it can allow continuing sufficient alertness to be accepted as a dignified and satisfactory time of continuing life, and may well lengthen that life's days.[62]

87 In turn, Prof Maddocks described Dr Hunt's reference to the removal of respiratory support from a person with terminal respiratory failure as 'not continuing life prolonging measures' consistent with the AMA Position Statement on the Role of the Medical Practitioner in the End of Life Care 2007 (amended 2014).[63]

88 Prof Maddocks had more difficulty in relying upon the 'double effect principle' to allow reconciliation of the two statements:

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61 Ibid [21], TB 92-93.

62 Prof Maddocks statement [22], TB 93.

63 TB 96.1.

1. That obtaining Nembutal would relieve the patient whose suffering had become intolerable; and
2. That there was no intention that the patient would use Nembutal to end his life.

> The difficulty for a satisfactory reconciliation of the two statements, is that while some suffering may be relieved simply by the assurance of having the Nembutal at hand, at the time when it is taken it will surely cause death. The paradox is similar to the international need to have a nuclear arsenal so that nuclear weapons will never be used, and raises complex arguments.[64]

89 Clause 10.7 of the AMA Position Statement, in part provides that:[65]

> If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:
>
> …
>
> The administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

90 Prof Maddocks did not consider there was any 'intellectual conflict' between the principle of double effect and clause 10.7 of the AMA Position Statement. However, he acknowledged differences of opinion in clinical practice regarding the use of deep sedation and whether at one level it was 'tantamount to euthanasia'. [66]

> Any potential conflict in clinical practice is best resolved through the open and honest communication with the patient (if possible), colleagues and family, following underlying principles of patient centred care, relationship and respect. Clandestine actions are to be avoided and intentions and agency made clear. A physician who has enjoyed a long professional relationship with the patient may feel too closely involved, and, may suggest involving another professional colleague to review the issues in conflict.[67]

91 Prof Maddocks referred to the importance of a multidisciplinary treatment team in the delivery of palliative care. However, he also acknowledged that in many circumstances a single experienced medical practitioner available, at call, if need be by telephone consultation, can provide appropriate advice and management.[68]

92 <u>Under cross-examination</u>, Prof Maddocks acknowledged Dr Syme as a very experienced and dedicated practitioner and accepted Dr Syme's professed experience and expertise in palliative care.

93 Prof Maddocks was taken through an extensive list of matters which Dr Syme had identified as important for a patient suffering a terminal condition. Prof Maddocks endorsed the approach adopted by Dr Syme as forming a proper ground work upon which to provide appropriate palliative care. He also agreed that the manner in which a practitioner conducts himself in this respect may inform the Tribunal as to that

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64 Ibid, [22], TB 94.
65 TB 96.1.
66 Ibid [23]-[[23], TB 94-95.
67 Ibid [24], TB 94-95.
68 Ibid [25], [26], TB 95.

practitioner's intentions, whether he has provided appropriate care and whether he intended to cause harm.

94 Prof Maddocks was referred to the AMA Position Statement.[69] Prof Maddocks endorsed each of the provisions of the Statement, while also acknowledging that there are very difficult issues in end-of-life care with the concept of 'double effect' which underpins clause 10.3, which states:

> All patients have a right to receive relief from pain and suffering, even where that may shorten their life.

95 Clause 10.5 of the Statement provides:

> The AMA recognises that there are divergent views regarding euthanasia and physician -assisted suicide.
>
> The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of futile treatment.

96 Clause 10.7 of the Statement provides:

> If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician assisted suicide:
>
> - not initiating life prolonging measures;
> - not continuing life prolonging measures;
> - the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

97 Prof Maddocks agreed that:

(a) The real issue here is: what is the subjective intention of the medical practitioner in regard to the relevant intervention;

(b) Patients in the terminal stage of their illness may experience severe and unremitting pain and sometimes also extraordinary psychological distress, driven by fear and anxiety;

(c) An important part of palliative care is to try to relieve 'existential suffering' which encompasses: feeling a burden to others, loss of social contact, isolation and loss of control;

(d) Where patients have a knowledge or belief of their capacity to improve control, this can have a significant positive effect upon their psychological suffering, which can in turn have an improvement upon their physical symptoms, including their perception of pain. Consequently, the patient may feel better able to function at home rather than require hospitalisation;

(e) In terminal palliation/sedation, where a cocktail of opioids and sedatives are continuously infused with the intention of relieving the patient's pain and distress, the patient will eventually succumb to unconsciousness and death. However, in reality, there are occasions where patients in terminal palliation do

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[69] TB 96.1.

not receive adequate relief for their pain and suffering; in these cases patients can frequently experience distressing respiratory problems; they may regain consciousness; intolerable pain may not be relieved; and they may experience a prolonged uncertain albeit inevitable death;

(f) Dr Syme's undertaking to provide Nembutal to a patient can provide that patient with a degree of control over their current and future circumstances; and that a number of patients who have received Nembutal have attested to this effect; and

(g) In the particular case of Mr Erica, the undertaking given to him by Dr Syme would appear to have improved the patient's quality of life, including his social engagement.

98 When asked whether giving physical possession of Nembutal to a patient would similarly provide the patient with a desired level of control, Prof Maddocks responded that he would prefer to use other legal drugs, which may provide adequate interim relief and sometimes a variation of dosage or another form of the medication may be the proper course of action. He agreed that some patients still do not respond; refuse increasing dosage or changing drugs, the only option then being terminal palliation.

99 Significantly, Prof Maddocks accepted that:

(a) If Dr Syme undertakes to give a patient Nembutal, without actually giving it, then such undertaking alone could be very helpful to the patient;

(b) If Dr Syme gives the drug Nembutal, with the intention of relieving a patient's existential suffering by providing the patient with more control but without the intention that the patient actually take the drug:

i. This may help the patient have control; then

ii. If the patient subsequently chooses to take the Nembutal, this is by analogy, a form of double effect; and

(c) The mere promise and possession of the drug can provide palliation; and

(d) Dr Syme could have had the intention to provide palliation to the patient by offering or providing the drug Nembutal, without intending that the patient actually take the drug.

Dr Roger Hunt

100 Dr Hunt is a Senior Consultant in Palliative Medicine, having practised in this discipline for over 30 years and for 10 years as director of a palliative care service. He is a founding Fellow of the Chapter of Palliative Medicine in the Royal Australasian College of Physicians. He has written and taught extensively about clinical ethics in end-of-life care and is a Senior Lecturer in the School of Medicine at the University of Adelaide.

101 Dr Hunt provided a written report dated 28 April 2016 and oral evidence before the Tribunal.

102 In his report Dr Hunt makes extensive reference to the statements made by Mr Erica and Dr Syme's submission to the IAC. He summarised his opinion as follows:

> Mr Erica held strong views about managing his suffering from terminal cancer and he wanted control over the end of his life. He wanted the availability of Nembutal, and he had tried to obtain it - this occurred before he approached and consulted with Dr Syme. It is clear that Dr Syme did not introduce the idea of Nembutal to Mr Erica, nor did he make Nembutal available to him.
>
> Dr Syme demonstrated that he understood the nature of Mr Erica's suffering and his values. Dr Syme offered meaningful reassurance and support that relieved Mr Erica's psychological and emotional distress and improved his quality of life.
>
> The evidence indicates that Dr Syme's primary purpose was the palliation of suffering, not the 'ending of a person's life'. His care was beneficial to Mr Erica rather than a risk to his well-being.
>
> It is a challenge for doctors to satisfy the wishes and interests of such patients and it appears Dr Syme was able to provide individualised care that was humane and effective.[70]

103 Dr Hunt noted Mr Erica's description of his physical and psychological suffering and in particular his fear of the kind of palliative care otherwise being offered to him. In his view:[71]

> Dr Syme effectively addressed Mr Erica's suffering and made him feel better… Mr Erica lucidly stated that Dr Syme achieved better palliation of his suffering than other practitioners and expressed his gratitude for Dr Syme's care. He also stated in his letter to the Medical Board 'my quality of life has plummeted since you have imposed those restrictions on Dr Syme'.
>
> I believe the current Medical Board did not properly acknowledge Mr Erica's psychological and emotional suffering and its successful palliation by Dr Syme. I suggest Dr Syme would provide benefit to similar types of patients.

104 In relation to Mr Erica's desire for Nembutal, Dr Hunt noted that:[72]

> In my practice of palliative medicine, I have cared for many hundreds of patients like Mr Erica who are fiercely independent and strong minded when confronting the reality of their illness and who want control over the ending of their life. Surveys show that 5 to 10% of terminal cancer patients request help to hasten their death.
>
> Mr Erica wanted to have Nembutal available to use if his suffering became too much; 'a peaceful way to end my life… with dignity and security'.
>
> Mr Erica rejected the option of palliative sedation … [in which]… death is hastened, but sometimes it can take weeks for the person to die.
>
> Mr Erica also rejected the idea of overdosing on morphine because of an uncertain outcome…
>
> From my experience, Mr Erica was correct to believe that an overdose of morphine may not produce his desired outcome of a quick death and he could survive to be in a worse situation, perhaps involving resuscitation attempts, anoxic brain damage and ongoing hospitalisation.

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70 Dr Hunt's report, TB 76.
71 Ibid, TB 77.
72 Ibid, TB 77-78.

105 In relation to Dr Syme's 'primary purpose', Dr Hunt noted that:[73]

> The intention of the clinician is inherently subjective, but to some extent it can be inferred from the nature of the doctor-patient relationship. If his primary purpose was to end Mr Erica's life, commonly called murder, Dr Syme would not have demonstrated:
>
> - quality communication in lengthy consultations
> - empathetic understanding and compassion for Mr Erica suffering
> - endeavours to palliate his suffering
> - respect for his autonomy (i.e. the patient's wishes)
> - ongoing psychological and emotional support
>
> It is reasonable to assume that Dr Syme's focus on these aspects of care indicates his 'primary purpose' was to palliate Mr Erica suffering and improve his well-being (which he achieved). By contrast, I think there was little to suggest that Dr Syme had, as the Medical Board put it, 'the primary purpose of ending a person's life'.

106 In relation to Dr Syme's undertaking regarding Nembutal, in Dr Hunt's opinion:[74]

> Dr Syme's counselling of Mr Erica involved tangible sympathy for Mr Erica's determination to acquire Nembutal. An outright rejection of Mr Erica's wish would have undermined the building of rapport and support.
>
> Dr Syme made two statements about Nembutal that may seem contradictory:
>
> 1. He said he would help Mr Erica obtain Nembutal if 'his suffering had become intolerable' and if he considered that 'Mr Erica was at the end of his endurance'.
> 2. He also denied any intention that the patient would use Nembutal to end his life
>
> I think the statements can be reconciled, however, using the 'principle of double effect'. This construct is used in clinical ethics and law to justify the widespread practice of palliative sedation. The clinicians' *primary intention* is to palliate suffering and the hastened death of the patient is regarded as a *secondary (unintended)* consequence.
>
> The double effect construct is also applied to the withdrawal of life sustaining treatments: the *primary intention* is to cease the treatment that is no longer beneficial to the patient and the foreseen death is regarded as *unintended*.
>
> Similarly, Dr Syme would say he could help Mr Erica obtain Nembutal with the primary intention to relieve his psychological and emotional suffering to improve his sense of control over the end of his life and to avoid Mr Erica otherwise embarking on a worse course of action in a distressed state (e.g. toward a premature or violent death).
>
> Hypothetically, even if Dr Syme made Nembutal available, it does not necessarily mean he intends for Mr Erica to actually take it. Indeed, Dr Syme stated it was not his intention 'that the patient actually take the medication' - he may really hope that Mr Erica chooses not to take it. It is noteworthy that in Oregon, where physician assisted dying has been legally practised since 1998, about 40% of patients provided with a legal prescription do not go on to take the drug.

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[73] Ibid TB 78-80.
[74] Ibid TB 79.

If Mr Erica took Nembutal when he was at the end of his endurance of intolerable suffering, then the application of 'double effect' would regard his death as a secondary (unintended) consequence of the primary (intended) purpose to palliate suffering, in much the same way as clinicians justify the hastening of death with palliative sedation.

107 In relation to Dr Syme's communication with other practitioners, in Dr Hunt's opinion:[75]

- It is up to Mr Erica to determine who should be his treating practitioners - he expressed dissatisfaction with palliative care options, so he sought out Dr Syme who agreed to be involved.
- Mr Erica has the right for his confidentiality to be respected, which could limit the involvement of other practitioners.
- Dr Syme had the responsibility to become properly informed about Mr Erica's case and gather any information from the patient and other practitioners that was necessary for proper care.
- Communication should flow both ways between the treating practitioners.
- Dr Syme should refer to colleagues for assessment and treatment as needed.
- Dr Syme is a very experienced practitioner in treating patients with advanced illness.

Terminal care is often provided by a multidisciplinary team to address the multidimensional nature of suffering and by practitioners across hospital and community settings. However, some patients develop a close therapeutic relationship with an individual practitioner and do not want others involved in the care. Dr Syme has made something of a specialty of caring and advocating for those patients who want control over the end of their life, whom other practitioners find very challenging and difficult to help.

108 Under cross examination, in relation to Dr Syme's intention in either offering or giving Nembutal:

(a) Dr Hunt confirmed his assessment that it was clear that Dr Syme's primary intention was to help Mr Erica deal with his illness, provide emotional support and palliate his suffering;

(b) Dr Hunt's evidence was to the effect that Dr Syme's actions were not consistent with a primary intention to assist to end a patient's life. The offer or provision of Nembutal gives a patient a certain amount of control, something which Mr Erica clearly craved. Dr Hunt accepted that Dr Hunt's intention could well have been to give such control;

(c) Dr Hunt agreed that by giving the drug Nembutal to a patient it also gives that patient an opportunity to use it, if they so choose. However, by providing such an opportunity, it does not follow that Dr Syme intended that the patient take the drug; and

(d) Dr Hunt accepted that Mr Erica sought Nembutal to give him control and assurance, with significant palliation of his symptoms.

[75] Ibid TB 80.

109 Dr Hunt confirmed that there are other circumstances, in palliative care, where a doctor may prescribe a drug without the intention that the patient will necessarily take it: such drugs as opioids, morphine, sedatives, which will render a patient not able to eat or drink and lead to terminal sedation. This type of treatment is intended to reassure a patient, whether or not the medication is actually utilised. In the case of terminal sedation, a patient (and the family on their behalf) wishes to die more quickly. Indeed, sometimes a person's suffering is only truly relieved when they die.

110 If Dr Syme had provided Nembutal, then Dr Hunt accepted that it could still be argued that this was equivalent to providing large doses of opioids and sedatives, in the context of terminal sedation.

111 While in the current legal framework, Dr Hunt cannot prescribe Nembutal, he does prescribe high doses of other drugs in the terminal phase of a patient's illness.

ANALYSIS AND FINDINGS

112 The factual circumstances upon which the decision of the IAC was based, are not in dispute and have been set out in detail above.

113 The Board may take immediate action, including the imposition of a condition on a practitioner's registration, if it reasonably believes that the practitioner's conduct poses a serious risk to persons; and it is necessary to take immediate action to protect public health and safety.

114 The Board bears the persuasive burden of establishing that the preconditions for the taking of immediate action are met.

115 The Tribunal understands that, when it made the Decision, the requisite reasonable belief of the Board was predicated upon the following facts and presumptions:

(a) Dr Syme promised to provide the drug Nembutal to Mr Erica, if certain circumstances exist in future;

(b) Dr Syme has admitted that he has similarly offered Nembutal and subsequently provided it to other patients;

(c) Dr Syme acknowledged that he could foresee that patients he supplied with Nembutal may take it;

(d) Once ingested at the recommended dose, Nembutal will cause the patient to die;

(e) Nembutal is currently not an authorised medication for the treatment of humans and it is not legally possible to prescribe the drug;

(f) The only or primary purpose in offering or giving possession of Nembutal to a patient is to assist that patient to end their life;

(g) The action in offering and the proposed action in providing possession of Nembutal poses a serious risk to persons by reason that its ingestion will cause death;

(h) There was a real possibility that Dr Syme would continue to engage in conduct that could be harmful to persons; and

(i) It was necessary and reasonable for the IAC to take the immediate action to protect public health and safety by imposing the Condition.

116 It is clear from the evidence that the above paragraphs (a) to (e) are not contested by Dr Syme, so that the focus of the evidence has been on the remaining paragraphs.

117 The Board's Counsel confirmed that while the Condition does not explicitly refer to any drug, it is intended to reinforce or highlight to Dr Syme that, in the Board's view, his conduct is inappropriate and as such constitutes a serious risk to persons.

118 The Board's Counsel also submitted that the Condition does not seek to restrict Dr Syme, in relation to other aspects of his practice, in counselling and advising patients with end-of-life issues.

119 The Board's Counsel acknowledged that any medical practitioner is currently prohibited from:

(a) providing a drug which cannot be legally imported or prescribed; or

(b) engaging in conduct with the primary purpose of ending life.

120 There is no question that the immediate action procedure is not a substitute for the action that a Board or the Tribunal may take after an investigation into allegations of professional misconduct or unprofessional conduct. Accordingly, both parties acknowledged that this proceeding is not conducted as if it were in the nature of a referral pursuant to s 193 of the National Law. Furthermore, the Tribunal is not concerned with:

(a) issues in relation to unprofessional conduct or professional misconduct; or

(b) the legality of either the undertaking to provide possession of Nembutal or the physical provision of Nembutal to persons.

121 The only question with which the Tribunal is concerned is whether the conduct of Dr Syme at the time when the Decision was made, poses the kind of serious risk that necessitates immediate action on an interim basis.

122 The Tribunal agrees with the submission of Counsel for Dr Syme that:

(a) The concept of serious risk means something more substantial than a concern that a practitioner may be engaging in unprofessional conduct or professional misconduct;

(b) There are many cases where no immediate action against practitioners is taken even though they are later found to have engaged in unprofessional conduct or professional misconduct and consequently have had their registration suspended or cancelled; and

(c) The focus of section 156 is at a level of serious and immediate risk to persons which cannot await the usual processes of investigation and hearing.

123 In assessing whether the IAC had reasonable grounds for taking immediate action, the Tribunal has regard to circumstances existing at the time when the Decision was made,[76] including:

(a) The evidence before the IAC;

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[76] *Pharmacy Board of Australia v Kozanoglu* (2012) 36 VR 656 at [106].

(b) Additional evidence bearing directly on the position as it was when the Decision was made;[77] and

(c) Exculpatory material which sheds a different light upon the allegations, such as the statements of Mr Erica and evidence of Dr Syme.[78]

124 In assessing what form that immediate action should be, the safety of the public must necessarily be the prime concern, with as little damage to the practitioner as is consistent with such concern.[79]

125 Applicant's Counsel submitted that the Board has not discharged its persuasive burden of establishing that Dr Syme engages in conduct that places persons at serious risk. Further and alternatively, even if his conduct were regarded as constituting such a risk, there was, and is, no basis on the evidence to form a reasonable belief that it was necessary to take immediate action.

126 The Tribunal proposes to adopt the format of written submissions made by Counsel for Dr Syme, which usefully identifies the key questions.

What is the conduct identified by the Board?

127 The specific conduct which has given rise to concerns by the IAC falls into two parts and relates to patients who contact Dr Syme seeking advice and support regarding end of life matters:

(a) The first part is the promise given by Dr Syme to Mr Erica, the subject of the notification, to provide possession of Nembutal. Dr Syme admits to having made a similar promise to about 10% of patients who contact him. After such promise was made to Mr Erica, Dr Syme continued to provide counselling and advice to him, indeed right up until days before the conclusion of the hearing. Dr Syme has not in fact been asked by Mr Erica to provide Nembutal;

(b) The second part relates to providing possession of Nembutal to a patient, which Dr Syme confirms has occurred in a smaller percentage of his patients.

128 The Tribunal accepts that Dr Syme has given frank and comprehensive evidence about how patients approach him; how he carefully and properly establishes rapport with patients; canvasses all relevant topics; and ascertains all relevant information necessary to make a proper assessment of the patient. Such evidence has not been contradicted by any evidence from the Board. The Tribunal further accepts that Dr Syme has demonstrated extensive and relevant experience and expertise in counselling terminally ill patients; and is relevantly informed about palliative care generally.

129 Furthermore, both experts have confirmed that Dr Syme has appropriate experience and expertise to advise and counsel patients, in the manner in which he has described. The Tribunal is also satisfied that the evidence of Dr Syme is consistent with the evidence of both experts, who outlined in some detail the kinds of matters to which a practitioner involved in palliative care should have regard.

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77 Ibid at [108].
78 Ibid at [110].
79 Ibid at [126].

130 The Tribunal also accepts Dr Syme's evidence about his purpose, or his intention, both in promising possession of Nembutal, and in providing possession of Nembutal, namely:

(a) That purpose and intention is the relief, or palliation, of the psychological and existential suffering being experienced by his patients; and

(b) The palliation occurs because patients feel an increased sense of control and certainty about how their life will end.

131 The Tribunal' assessment of Dr Syme's evidence is significantly reinforced, in this regard, by the evidence of both experts, both of whom confirmed that there is a role for palliation of psychological distress and existential suffering, through provision of control:

(a) Prof Maddocks agreed in evidence that it was clear that there was a palliative effect or benefit to patients who were given access to Nembutal and by reason of that access, had a sense of control over their own future;

(b) Dr Hunt noted that in Oregon, where a drug similar to Nembutal can be prescribed, 40% of people given the opportunity to take the drug do not in fact use it, and the intention of the prescriber in that instance is not to have patients take it but to give them a sense of control over their own destiny;[80]

(c) Dr Hunt accepted, consistent with Dr Syme's evidence, that the intention of Dr Syme could well have been to give Mr Erica control, rather than an intention to have him ingest Nembutal and thereby end his life;

(d) Dr Hunt also confirmed that the circumstances of Mr Erica and the wishes which he has expressed are common to a small but significant group of terminally ill patients for whom the current regime of palliative care does not always meet their needs for control or relief from intolerable pain and suffering; and

(e) Under cross examination, Dr Hunt also accepted that Dr Syme's undertaking to Mr Erica to provide possession of Nembutal had a palliative effect in itself and that the actual possession of Nembutal could similarly serve the purpose of giving Mr Erica the relief through a sense of control, without Dr Syme ever intending that the drug be ingested.

132 The Tribunal has also been significantly assisted by the unchallenged and articulate statements provided by Mr Erica. Consistent with the evidence of Dr Syme, Mr Erica believes that his psychological and existential suffering has been significantly improved by the counselling provided by Dr Syme and his offering of assistance to provide Nembutal, in the event that circumstances warrant such action. Mr Erica also refers to an improvement in his physical well-being and purpose in life. Mr Erica eloquently describes his desire and need to have control at the end of his life and in the final process of his dying. He has sought and received appropriate advice concerning alternative palliative care in hospital and at home and has soundly rejected both options. His reasoning is considered and expressed in a rational manner.

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[80] Dr Hunt's report, TB 79.

133 Counsel for the Board submitted that further circumstances which came to light in evidence before the Tribunal are also relevant to the risk posed by Dr Syme's conduct, namely:

(a) his lack of systematic record-keeping;

(b) the lack of complete medical information about his patients; and

(c) his lack of any specific qualifications in counselling, psychology or psychiatry, where he purports to treat patients' psychological and existential suffering.

134 In the Tribunal's view, none of these matters, having regard to the evidence given by Dr Syme, which we accept, create a circumstance of material risk and in any event, are not sufficient to warrant immediate action. In particular:

(a) The IAC did not explore Dr Syme's record-keeping practices or other information and records obtained from patients generally;

(b) It is quite unfair and inappropriate for Dr Syme to account for his records and knowledge of patients generally, when being cross-examined before the Tribunal, when the focus of the Board's enquiry related to one patient arising from one notification only;

(c) Dr Syme's account of his knowledge and examination of Mr Erica was comprehensive and was not in any respect criticised by either expert;

(d) Dr Syme does not seek to treat a patient's underlying condition or illness or replace their treating doctors. Many patients are recommended to explore treatment options which Dr Syme considers are clearly available to them. Many patients are directed to traditional palliative care services, which proved to satisfy their needs. Many patients are assisted by Dr Syme's preparedness to listen to their fears and answer their questions. For approximately 90% of those patients who contact him, no question of the offer or provision of Nembutal ever arises. In the case of Mr Erica, Dr Syme was at pains to point out that he was satisfied that Mr Erica was under the care of a team of cancer specialists and it was not his role to second-guess their advice. Indeed it would be unrealistic for him to be an expert in the treatment options for all of his terminally ill patients; and

(e) The Tribunal is also satisfied, as confirmed by the evidence of both experts, that Dr Syme is eminently qualified and experienced to give advice and counselling in regard to the palliative care of terminally ill patients, including whether a particular patient would benefit from a referral to a psychologist or psychiatrist.

Intention v Purpose and relevance to identifying the conduct

135 The Board contends that the primary purpose of giving Nembutal to a patient, in the circumstances of this case, necessarily is to end that patient's life. To this end, the Board equates 'purpose' with the chemical effect upon a person actually taking the drug - the subjective intention of the practitioner in providing the drug or indeed the subjective intention of the patient, in taking possession of the drug, is irrelevant.

136 In the Tribunal's view, the Board's construction of the Condition it has imposed wrongly conflates 'purpose' with 'effect'. It contends that, since the chemical **effect** of the drug if ingested is death, that can be the only **purpose** for Dr Syme promising or providing it. Such a rigid construction ignores the reality of the palliative effect,

contended by Dr Syme and confirmed by Mr Erica and anecdotally, by other patients in precisely his position.[81]

137 It should be emphasized that the Tribunal is not concerned in this application with the illegality or otherwise of Dr Syme's conduct in obtaining the drug Nembutal or giving it to a patient. However, the Tribunal notes that Dr Syme's conduct in this respect could hardly have been more public and there is no evidence before the Tribunal that he has ever been investigated, charged or prosecuted for any related breach of the law.

138 In the Tribunal's view, Counsel for Dr Syme also identified, correctly, that purpose and effect are different concepts in medicine:

(a) Purpose is the subjective intention of the practitioner in providing a treatment or intervention; and

(b) Effect is the objective outcome of the treatment on the patient.

139 The Tribunal agrees with Counsel for Dr Syme, that the reference to 'primary purpose' in the Condition necessarily refers to the intention or mind of the practitioner. However, instead of ascertaining such intention, the Board relies upon an interpretation which simply equates the purpose of a medical intervention to the chemical effect of the drug.

140 It is significant that neither expert witness agreed that the effect of Nembutal, if ingested, prevented Dr Syme from having the intention of providing possession of Nembutal for the purpose of relieving his patients' psychological suffering. Indeed, there is no evidentiary support for the Board's contention that the chemical composition of Nembutal inevitably means a purpose of ending life, when mere possession of it is given in the circumstances which Dr Syme has described.

141 Both Prof Maddocks and Dr Hunt agreed that the intention or purpose of any medical intervention is determined by reference to the intention of the doctor providing the intervention:

(a) Prof Maddocks said the relevant intention is Dr Syme's; and

(b) Dr Hunt noted that whilst inherently intention is a subjective matter, it can be inferred from the nature of the doctor patient relationship. He said that the way in which Dr Syme demonstrated quality communication and empathy, attempted to palliate suffering, respected his patient's autonomy and provided ongoing support, suggested a focus on wellbeing and palliation rather than on ending Mr Erica's life.

142 The Tribunal accepts that the consistently stated subjective intention of Dr Syme, to palliate his patients' psychological and existential suffering, is objectively verified by the evidence of how he assesses and counsels patients, such approach being entirely inconsistent with a sole or primary intention or purpose simply to end a patient's life.

143 In summary, the evidence of intention and purpose is:

(a) Dr Syme intends to relieve psychological and existential suffering;

(b) Dr Syme's observation of patients who have been given a promise or possession of the drug is that their quality of life significantly improves by palliating their

[81] See also Ex B, Age newspaper article 11 May 2015, giving an account by patient Ray Godbold.

psychological and existential suffering; and many choose not to take the drug either at all or not for a considerable time after receipt;

(c) Both experts agreed that his actions could and do serve that purpose and that a real benefit could be obtained by patients from being promised or given possession of Nembutal; and

(d) The unchallenged evidence of Mr Erica demonstrated the effect of palliation of his psychological and existential suffering through the undertaking provided by Dr Syme.

144 The Tribunal also agrees that the Board's case fails to acknowledge the critical distinction between **possessing** and **ingesting** Nembutal:

(a) Dr Syme gives Nembutal to patients so that they have it in their possession;

(b) Patients seek to possess Nembutal so as to be in a position to control their own future;

(c) In both cases, the purpose and intention is that Nembutal be possessed, not that it be used; and

(d) The possession of the drug provides palliation of the otherwise severe psychological and existential suffering the patient was experiencing (a proposition to which both Prof Maddocks and Dr Hunt agreed).

145 The fact that Nembutal, if ingested, will cause death is admitted, is obvious and has never been in issue. However, the temporal distance between when Dr Syme provides possession and when, or if, the patient elects to use it, is further confirmation that **ingestion** is not the purpose for, or intention with, which he provides it. The ingestion of Nembutal requires the independent, voluntary decision and action of the patient. The action of Dr Syme in providing the drug does not inevitably lead to such ingestion and does not, of itself, cause death.

Relevance of the principle of double effect

146 The principle of double effect was addressed at some length by the experts in both their written reports and oral evidence. It is relied upon as the underlying rational for terminal sedation. While Prof Maddocks would not use the word 'justify' when describing such a principle in the context of terminal sedation, this is really a matter of semantics. Terminal sedation, conducted in accordance with the principle of double effect, complies with clause 10.7 of the AMA Position Statement.[82] Although Dr Syme was reluctant to express direct reliance upon such a principle, explaining his conduct as analogous to terminal sedation, the Board's position is that the principle clearly has no application to the impugned conduct of Dr Syme.

147 In the Tribunal's view, the Board's position is untenable for the following reasons:

(a) The Tribunal accepts that Dr Syme's intention in either promising to provide and subsequently (in some cases) actually providing Nembutal, is not for the primary purpose of ending that patient's life;

[82] TB 96.1.

(b) Dr Syme clearly contemplates that a patient in possession of Nembutal, may at some stage decide to ingest it, in which case death will be inevitable within a relatively short time;

(c) To the extent that the possession of Nembutal gives the patient the opportunity to make the decision to actually ingest it, then the act of ingesting can be described as a potential consequence of such possession;

(d) The principle of double effect recognises that some forms of medical care at the end of a patient's life can have the effect both of easing symptoms of pain and suffering and also of hastening death. Where the doctor intends the former, the latter is accepted as an unintended consequence;[83]

(e) The Tribunal recognises that the description of death as an 'unintended consequence' is somewhat strained where in fact, once terminal sedation is initiated, for the primary purpose of relieving pain, death is inevitable - it is only a matter of timing;

(f) The treatment Dr Syme provides is directed to the relief of psychological and existential, rather than physical, suffering. He palliates that psychological and existential distress by promising to provide, and in some cases providing, physical possession of Nembutal;

(g) Dr Syme's evidence is that he does not intend patients to take the Nembutal but he can foresee that they might. He provides it in advance of the final phase of life because it is provided, not to be ingested, but to be kept accessible to the patient. The possession affords the patient control which in turn has the effect of significantly palliating psychological suffering. To this point, it cannot be said that Dr Syme's conduct poses a serious risk;

(h) Furthermore, in the Tribunal's view, the mere promise of, or provision of possession of, Nembutal, in the circumstances described by Dr Syme, does not cause the patient's death. Dr Syme's treatment has no immediate secondary effect; the evidence is that patients do not ingest Nembutal as soon as it is given to them and that they may not ever ingest it at all. To that extent the principle of double effect has no direct application for such patients;

(i) However, although not a classic instance of double effect, the process by which some patients who are given Nembutal, choose to die by ingesting it, is analogous to the process of terminal sedation, where a mixture of opioids and sedatives are used. In each case, the intended and established purpose of treatment is palliation of suffering. The fact that the treatment also has the effect of providing an opportunity for the patient to later ingest the Nembutal is not intended by Dr Syme and can be seen as a secondary but unintended consequence.

148 The Tribunal agrees that there is a logical analogy between the principle of double effect used in palliative care; and the prospect that a patient may elect to ingest Nembutal, the latter effectively representing the same kind of secondary effect as the hastening of death which Dr Hunt said occurs when terminal sedation is used. The only real difference is one of timing. When Nembutal is ingested in the requisite dose,

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83 Both Prof Maddocks and Dr Hunt acknowledged that death in these circumstances is seen by both patient and family as beneficial or desirable as the intended purpose of easing pain.

the process leading to death is quick and without the further trauma or complications which can be associated with terminal sedation.

149 Although there is no suggestion that the AMA Position Paper implicitly endorses the provision of a drug such as Nembutal to patients, in the Tribunal's view, Dr Syme's intention in promising or giving the drug, is consistent with clauses 10.3 and 10.7.

Persons possibly at risk from Dr Syme's conduct

150 The Tribunal refers to and adopts the submissions made by Dr Syme's Counsel regarding persons who could conceivably be at risk from Dr Syme's conduct.[84]

151 Dr Syme's patients are a small subset of the cohort of patients who are facing terminal or severe degenerative illness. They are -

(a) Self-selected, in that they seek him out rather than coming into his practice through chance or in the course of receiving other treatment; and

(b) Self-identified as those for whom there is a risk or concern that traditional palliative care methods will prove inadequate because of a potential loss of control.

152 That subset is then -

(a) Screened by Dr Syme to ensure they are rational and competent and not influenced by family;

(b) Screened too by Dr Syme to assess their degree of suffering based on factors including existential and psychological factors; and

(c) Encouraged to take advantage of options for further treatment and palliative care, where those are available and acceptable (which on the evidence often results in their concerns about loss of control being allayed).

153 After that process, a percentage are provided with advice and support regarding their end of life options. Dr Syme's evidence is that that percentage consists of those with terminal cancer or advanced degenerative conditions.

154 Accordingly, only a subset of a subset of patients fall into the category of those who could be in receipt of either a promise of the physical possession of Nembutal or the actual physical possession of Nembutal from Dr Syme. Those patients:

(a) Are experiencing suffering which is, or is anticipated to be, intolerable to them and not able to be relieved by other methods;

(b) Are facing death from a terminal disease or advanced degenerative disease;

(c) Are seeking advice and support on a subject matter of great significance to them and in relation to which they already have a strong view (or they would not have sought out Dr Syme);

(d) Remain under the care of their general practitioner and other treating specialists;

(e) Are assessed by Dr Syme before he gives an undertaking to provide physical possession of Nembutal and again before providing the actual physical possession of Nembutal;

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[84] Counsel's written submission [35]-[43] dated 23 November 2016.

(f) Are seeking Nembutal to relieve, by means of a sense of control over their future, the psychological and existential suffering they are experiencing; and

(g) May or may not choose to ingest Nembutal.

155 The Tribunal accepts Dr Syme's evidence that the promise of Nembutal, and later the provision of the possession of Nembutal, has a significant impact on improving a patient's level of psychological suffering, and sometimes by association, their physical state. Such evidence was also supported by the evidence of both experts, and by the unchallenged evidence of Mr Erica.

156 In the Tribunal's view, Dr Syme's conduct does not and does not seek to create a competitive option to traditional palliative care. On the contrary, Dr Syme works within a palliative care environment and provides counselling and advice to the vast majority of his patients without any reference to Nembutal. However, some patients who approach Dr Syme share the following circumstances:

(a) They are, or apprehend that they may be, in the minority (perhaps) of cases where traditional palliative care will not work;

(b) They have suffering which, they believe, is not amenable to any form of palliative care without an accompanying loss of control;

(c) They have existential and psychological suffering for which there is no medical treatment available in palliative care short of terminal sedation; and

(d) They seek control, or an assurance of future control, as a means of easing their psychological and/or existential suffering.

157 Dr Hunt gave evidence which strongly identified with such a cohort of patients, who represent a very difficult body of patients for the palliative care physician. In particular, Dr Hunt noted that the fear and worry can be 'an awful cloud hanging over' patients. He said some people want to be in control and say they do not want terminal sedation, He noted that this was particularly true of independently minded people who have been in control of their own lives. He said it was a very difficult situation to confront for a doctor, because such a patient will be dissatisfied without having control. He said that Dr Syme is trying to help that really difficult group of patients who are not getting that help from other practitioners. Mr Erica got help from Dr Syme where other doctors had been of no assistance to him.

158 Prof Maddocks noted the central importance of asking patients – what is important to you? Dr Syme gave evidence that he does that. His small cohort of patients are those for whom control is important.

159 In the Tribunal's view, the above described cohort of 'persons' can only be the persons whom the Board contend are at serious risk from Dr Syme. For the above reasons, further elaborated below, the Tribunal does not accept that there is any basis for reaching a reasonable belief that the conduct of Dr Syme does in fact place such persons at serious risk.

What is the serious risk?

160 The Tribunal, having accepted the evidence that the provision of Nembutal can and does have a palliative effect, the question becomes – does that provision nevertheless pose a serious risk such that immediate action is necessitated?

161 The serious risk of harm, namely death, which the Board contends is inherent in Dr Syme's conduct, is manifest by patients reaching a stage where they wish to exercise the control that they have been given (namely by possession of the drug Nembutal), and making the decision to ingest the drug and die. To use the analogy of double effect, the risk identified is the potential subsequent and secondary effect of ingestion.

162 In the Tribunal's view, the Board's approach is overly simplistic and mechanistic:

(a) On Dr Syme's evidence, some patients never choose to ingest the Nembutal given to them, being sufficiently reassured by the sense of control that the promise of possession and actual possession provides, and continue to live without the severe psychological and existential suffering that they would otherwise experience. No serious risk can arise in such cases;

(b) The Board's position also ignores the fact that a rational and competent patient may reach a stage when they choose not to endure any further intolerable suffering or rely upon traditional palliative care. The fact that some patients do choose to ingest Nembutal, often not for a significant period after being in possession of the drug, a prospect which Dr Syme clearly envisages may happen, does not, in the Tribunal's view, detract from or invalidate Dr Syme's original intention; and

(c) The Board effectively dismisses or discounts:

i. the right of any individual of sound mind to seek reassurance that they will be able to, if they wish, control the manner of their dying;

ii. the palliative effect upon such a patient, knowing that they are dying; and

iii. that the reassurance of the promise or actual possession of the drug does not, from the patient's perspective, place them at any risk.

163 In the Tribunal's view, in assessing whether Dr Syme's conduct poses a serious risk to any person, it is also significant that:

(a) According to Dr Syme's un-contradicted evidence, he only undertakes to provide possession, or provides possession of, Nembutal in circumstances where he is satisfied that the person is of sound mind and has reached a stage where their disease is progressing in a manner beyond reach of further medical intervention and that the patient's level of suffering requires the provision of his undertaking to provide or alternately the provision of the possession of Nembutal;

(b) Dr Hunt noted that there are some things worse than death. Sometimes suffering only ends with death. Asked if there was a "risk" patients would take it, Dr Hunt preferred to use the word "opportunity" – indicating that access to the drug by the particular cohort cannot necessarily be said to be placing them at risk;

(c) Prof Maddocks noted that for a certain cohort of patients, death may be seen as a benefit and not a harm and that he has himself had patients where that view would be logical and appropriate;

(d) Dr Syme can foresee that Nembutal provided by him may be ingested but he has no intention or wish that that occur. Whether it is ingested is ultimately a matter for the patient, whose sense of their own suffering and when it becomes

intolerable, remains central and paramount. The intention to end their life is their own, it is not the intention of Dr Syme;

(e) Both experts gave evidence that it is their understanding of the current law, rather than any concern that it would be poor medical practice, that keeps them from doing what Dr Syme does:

  i. Prof Maddocks in his email to Dr Syme (exhibit A) said that he would ‘wish to be able to walk with [his patient] to the end’; and

  ii. Dr Hunt said that he does not use Nembutal because it is not legal to use it, but that if it were legal there could be cases where he would prescribe it; and

(f) The fact that a form of medical treatment is not lawfully able to be provided in Australia does not of itself indicate that it is a medical treatment that places patients at serious risk. Indeed, Prof Maddocks noted in his first report that the prescription of drugs similar to Nembutal is lawful in some jurisdictions.

164 In relation to Dr Syme’s risk to Mr Erica, the subject of the notification, it is appropriate to recall the evidence of Mr Erica, to the effect, that prior to making contact with Dr Syme:

(a) He had already attempted to obtain possession of Nembutal;

(b) He had already rejected other palliative care options to end his life;

(c) Knowing that he was dying and already experiencing severe pain and mental suffering, he had already decided to end his life, if his pain and suffering became intolerable; and

(d) He had already decided that, if his pain and suffering became intolerable and he was unable to source Nembutal, he would be driven to end his life by more violent means.

165 In these circumstances, the Tribunal is satisfied that the conduct of Dr Syme is not consistent with an intention to assist Mr Erica to end his life and did not otherwise pose a risk of harm to him. In particular:

(a) The mere offering of support to provide the drug, if the circumstances warranted, taking the offer as a genuine and truthful undertaking, was intended to and did in fact provide significant palliative care, in the ways described by both Dr Syme and Mr Erica;

(b) Mr Erica maintains that Dr Syme’s care of him improved his psychological health, and this is consistent with the evidence of both experts about the value of control to patients;

(c) The mere giving of possession of the drug, if in fact that were to occur, equally does not crystalize an intention to take it, either by Dr Syme or the patient;

(d) Neither the offer nor the actual provision of the drug, carries with it the necessity that the drug will be taken. Such further step in any event requires the independent, considered and rational decision of the patient who has rejected other palliative care options which may be available;

(e) It is entirely plausible that Dr Syme did not intend that his patient/s take the drug. Those patients who have chosen to take that further step, did so by independent voluntary decision, without the presence, knowledge or assistance of Dr Syme; and

(f) Many patients who had been given possession of the drug chose not to take it before they died by other means. Many who did ultimately choose to take the drug did so after a further and sometimes significant lapse of time.

166 The Tribunal accepts that Dr Syme has given frank, comprehensive and cogent evidence that:

(a) his primary intention in either undertaking to give or actually giving possession of the drug Nembutal to a patient is to palliate their severe psychological and/or existential suffering;

(b) that the primary purpose in either undertaking to give or actually giving possession of the drug Nembutal to a patient is to give that patient control over the ultimate means to end their life, if the patient so chooses; and

(c) he does not intend that any patient will actually use the Nembutal to end their life.

167 Furthermore, the Tribunal accepts that the position advanced by Dr Syme is both credible and reasonable, having regard to the total circumstances in which he counsels patients generally; and the exceptional circumstances of the special subgroup of particular patients who may ultimately choose to take the Nembutal provided to them.

168 The Tribunal also notes that no witness was called to give evidence of adverse outcomes or complaint about the manner in which Dr Syme practises, including any concern that a person was given Nembutal, other than in the circumstances Dr Syme has described.

169 In the Tribunal's view, consistent with the opinions of both experts, the choice of a rational patient who elects to end their life rather than endure further intolerable suffering and an uncertain death by means of other palliative care options, is not a death which can be described as harmful for that patient.

170 In the Tribunal's view, on the evidence, there is no basis to form a reasonable belief that Dr Syme poses a serious risk to persons.

The necessity to take immediate action

171 Even if the Tribunal had formed a reasonable belief that Dr Syme's conduct does pose a serious risk to persons, the Tribunal must also be satisfied that it is necessary to take immediate action to protect public health or safety. In this regard, the following circumstances are relevant:

(a) While some patients are referred by their own medical practitioners, most independently seek Dr Syme's counsel and advice. Accordingly, his patient cohort is a small self-selected group, who will mostly have their own treating doctor/s or if not, are at an early stage where they may be seeking more general advice and information for the future. Accordingly, there is no prospect of anyone coming into contact with Dr Syme unless they take active steps to do so.

Dr Syme consults with only those patients who seek him out. There is no impact on public safety beyond those patients; and

(b) Dr Syme offers advice and assistance within limited parameters. He does not replace a patient's existing treatment team, although from his own experience and expertise, he may advise patients to investigate other treatment options.

172 In the Tribunal's view, neither of these circumstances gives rise to a reasonable belief that immediate action is necessary to protect public health and safety.

The form of immediate action taken

173 The Condition imposed on Dr Syme is predicated upon the proposition that he engages in conduct, in the course of his medical practice, which has the primary purpose of ending a life. The Board in fact goes further and submits that such purpose is necessarily implicit in his conduct and that any expressed subjective intention is irrelevant.

174 For reasons outlined above, the Tribunal rejects the underlying premise of the Board's reasonable belief. Dr Syme does not force any patient to ingest Nembutal, he is never present when it is ingested by any patient and on his evidence, other than giving instructions as to the requisite dose and the likely effect of ingesting the drug, he does not advise patients that they must or should take it. It is untenable for the Board to reason back from the ultimate effect of ingesting the drug that the intention or purpose of Dr Syme in offering or giving it, is necessarily to end that person's life.

175 As indicated above, the Tribunal is satisfied that there is credible and persuasive evidence from Dr Syme that his intention is to palliate psychological and existential suffering and that from his extensive experience, that is precisely the desired effect which his conduct in offering or giving the drug Nembutal in fact has upon his patients. Furthermore, Dr Syme consistently denied that his primary purpose or intention in offering or giving Nembutal or indeed any other aspect of his counselling and advice, was to end a patient's life.

176 The Tribunal further accepts that the evidence of both experts is supportive of the intention expressed by Dr Syme, to the extent that such intention is entirely reasonable in the circumstances and that his conduct would be likely to have the palliative effect claimed for his patients.

177 The Tribunal agrees with the submission of Dr Syme's Counsel that the Condition is oppressive, if predicated as described above, upon a deemed purpose. Furthermore, the Condition is unworkable to the extent that it relies upon an assessment of the subjective intention of the medical practitioner, which is inherently difficult to assess and monitor. On these grounds alone it should be set aside by reason that it is inherently oppressive, unworkable and uncertain in its operation.

178 In addition, to the extent that the Condition purports to merely prohibit what is currently prohibited under the law, then such Condition effectively supplants the burden of proof applicable to criminal conduct with an entirely different burden of proof applicable to professional misconduct of the medical practitioner. On this basis alone, the Tribunal finds the Condition objectionable and contrary to the power and discretion afforded to the Board by s 156 of the National Law.

CONCLUSION

179 The Tribunal is satisfied that the holistic approach adopted by Dr Syme is entirely focused upon supporting the patient in life rather than pre-empting the patient's death. Mr Erica is a perfect example. When he first approached Dr Syme, he did not want to die. He merely wished to avoid an uncertain death, either in hospital away from family or at home where he could still not have control over the timing and circumstance of his death. It is no longer illegal to commit suicide. Although Mr Erica's preferred option is to ingest Nembutal, currently an illegal substance, if his pain and suffering becomes intolerable, the only other option he was prepared to countenance was a likely premature and violent death by other means. It is not the function of the Tribunal in this review to pass judgement upon the legality or otherwise of Nembutal or the choice which patients such as Mr Erica make to end their life by using this drug, if they can obtain possession of it.

180 The question of whether a drug such as Nembutal ever becomes relevant is limited to a small subset of the patients who seek Dr Syme's advice and counselling. A number of those patients who are given significant relief from their mental suffering, by the offer of assistance, may in turn never actually request possession of the drug. In turn, the request for possession is not automatically met but is subject to further counselling and assessment. While the final number who actually have taken the drug cannot be precisely quantified, anecdotally and from the feedback of relatives who hand back the unused drug, the evidence supports the contention of Dr Syme that the undertaking to provide and the actual possession of the drug, of themselves, provides significant palliative relief and ought not be conflated with a subsequent decision of the patients, whose suffering becomes intolerable, to end their life in the quickest and most peaceful manner available to them.

181 The Tribunal is satisfied that there was no evidence, at the time when the Decision was made by the IAC, to the effect that any conduct of Dr Syme was intended to or did cause harm to any person. The Board has equated the ultimate death of a patient, by ingestion of Nembutal, as harmful. Dr Hunt recognised that for these patients death is a relief. The Tribunal recognises that these patients have chosen a relatively quick and peaceful death rather than the undignified, painful, unpredictable and possibly protracted alternative death following intolerable suffering.

182 The position articulated by Dr Syme is also strongly supported by the evidence of Dr Hunt in particular and has qualified support from Prof Maddocks.

183 The Tribunal is also satisfied, on the evidence presented before it, that Dr Syme does not and does not seek to replace or interfere with the provision of treatment of other medical services to his patients. Furthermore, Dr Syme is clearly an experienced and respected specialist who also recognises the importance of palliative care options and has also acquired extensive experience in counselling terminally ill patients.

184 In conclusion, for the reasons given, the Tribunal is comfortably satisfied that the Decision of the Board does not satisfy the terms of s 156 of the National Law by reason that:

(a) There is no evidence to support a reasonable belief that, because of his conduct, performance or health, Dr Syme poses a serious risk to persons generally or Mr Erica in particular; and

(b) Further or alternatively, it was not necessary to take immediate action to protect public health or safety; and

(c) Further or alternatively, the Condition is objectionable and not a valid condition to impose upon one practitioner alone, to the extent that its purpose and effect is merely to restate the law; and

(d) Further or alternatively, the Condition is oppressive, unworkable and uncertain as to its precise terms, operation and enforcement.

185 Accordingly, the Tribunal determines that the application for review be granted and pursuant to s 202(1)(c) of the National Law, the Decision under review, namely the imposition of the Condition, be set aside on the basis that the Tribunal is not able, in accordance with s 156(1)(a) of the National Law, to form a reasonable belief that Dr Syme's conduct places persons at serious risk or that it is necessary to take immediate action to protect public safety.

Judge Jenkins **Vice President**	**Dr Brian Collopy** **Member**	**Dr Patricia Molloy** **Member**