

Opening Statement to the Joint Committee on Assisted Dying (Ireland)
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Thank you for the invitation to appear before the Joint Committee today.

For 22 years I was a General Practitioner in the large regional centre of Bendigo, Victoria, Australia. During that time I developed a special interest and expertise in palliative care, completing a postgraduate diploma in palliative medicine at the University of Melbourne.

In 2005 I commenced specialist training in palliative medicine in Melbourne and was awarded a Fellowship of the Australasian Chapter of Palliative Medicine in 2007.

Since then, I have practiced as a specialist palliative care physician in another large Victorian regional centre, Ballarat, until my semi-retirement in January 2023.

In 2018 I was invited to serve on the Victorian Government's Voluntary Assisted Dying (VAD) Implementation Taskforce which was given the responsibility of guiding the introduction of the Victorian VAD Act into practice. This 18-month implementation period proved vital in setting the scene for accessibility and viability of VAD as an end-of-life option in our State.

Since the VAD legislation came into effect in Victoria on June 19th 2019, I have been involved in the assessment of more than 80 patients who have requested access to VAD. I have acted as either the Co-ordinating Medical Practitioner or the Consultant Medical Practitioner for 73 of those patients. Of the 49 patients for whom I have been their Coordinating MP:

- 18 died before completion of the VAD process
- 6 cases were withdrawn (lost capacity or decided not to proceed)
- 21 patients died by self-administration of the VAD substance
(14 in own homes; 4 in our local palliative care unit; 2 in nursing homes, 1 in small regional hospital)
- 1 patient died at home by intravenous practitioner administration, performed by me.

The important things that I have learned throughout this involvement with VAD are as follows:

1. These people did not want to die – they would much rather have lived and, without fail, their families wanted them to. However, they had a terminal illness from which they were going to die and they had reached the limits of their suffering.
2. They came from all walks of life – a wide variety of socioeconomic, educational and religious backgrounds.
3. Only a very small minority were what some people have labelled (pejoratively) as 'control freaks'. However, they were, without exception in my experience, very determined people who had firm, well-considered views about how they wanted to manage the end of their lives with a terminal illness.
4. All had access to excellent palliative care, from our multidisciplinary teams either as inpatients or in the community (or both).
5. The issues of coercion, cognitive impairment and severe depression, as adverse factors in informed decision-making, are screened out at initial interviews and are not issues of

substantial importance in practice as long as vigilance is maintained (as it should be in any other area of medical practice).

6. These people are not “suicidal” and are, without exception, offended by the implication of mental illness.

In summary, my practice, and those of a number of my palliative care colleagues here in Australia, is living proof that VAD, as a valid and now legal end-of-life choice, is not at odds with the overall aims of palliative care, that is to use a patient-centred approach to support people with advanced, progressive, incurable illness (and their families) and relieve suffering wherever possible.