

## VOLUNTARY ASSISTED DYING BILL 2019

### *Second Reading*

Resumed from 26 September.

**The PRESIDENT:** Before I give the call to Hon Nick Goiran, I will remind members that we have in front of us a very complex, complicated and contentious bill. Obviously, members will be speaking about very personal matters and, at times, it will be emotional. It is a bill on which their respective parties have given all members a conscience vote. All I ask is that we treat each other with respect during this debate and note that there is a difference of opinion around the chamber.

**HON NICK GOIRAN (South Metropolitan)** [2.20 pm]: I rise as the lead speaker for the opposition on the Voluntary Assisted Dying Bill 2019. The Liberal Party's position on this bill is to grant each of its members a free vote. Of course, it is always the case that Liberal Party members are able to vote in accordance with their conscience on any legislation, but from time to time our party takes a particular position authorising its members to have a free vote and, therefore, not to have to advise the party room of their position on a piece of legislation. This is one such bill. As you have already foreshadowed, Madam President, I understand that the other parties have taken a similar position on this matter. At the outset, I urge members as we consider this legislation to block out the noise and collectively—all 36 of us—wrestle intellectually with the matters before us. If I do nothing else during this speech today, I appeal to members to collectively reason through this process. Conscience votes are very rare in this Parliament. This is not the first time a euthanasia bill has been before the Parliament. In fact, I recall us dealing with a bill in 2010, in my first term, that was brought forward by my parliamentary colleague Hon Robin Chapple. Members who were there at that time may recall that the second reading of that legislation was defeated 24 votes to 11. On that occasion, any members who wanted to speak were able to do so and a vote was taken. I see no reason that same process cannot take place with the bill before the house.

If this bill is to be defeated after an intellectual wrestle, after members have reasoned through the process, it will not be unusual. In fact, some 50 bills in our nation have failed on this particular topic. I note that as recently as 2017 in the United States of America some 43 bills were presented across 26 states, all of which failed. It is not particularly unusual after an intellectual wrestle and a reasoning process has occurred for a chamber of Parliament to say no to voluntary euthanasia and assisted suicide. As we consider this particular bill, the technical question before the house at the moment is: should this bill be read a second time? However, I put to members that a more important question needs to be considered by members before they decide how they are going to vote on this legislation. The question that I believe every member in this chamber has a duty to answer is: is it possible to design and implement a safe euthanasia regime? That is the threshold question for every single member in this place before they cast their vote.

As members consider that question, it is not acceptable, it is unsatisfactory, and it is not becoming of a member of this place, a lawmaker, a person who has the responsibility on behalf of Western Australians of having the final say on legislation, to simply say, "Yes, I think it is possible", because anything is possible. That is not an acceptable answer to that question. If members believe that it is possible to design and implement a safe euthanasia regime, there is a duty to identify the jurisdiction that has done so. If it is the case that a member in considering this process and reasoning through the process is unable to identify a jurisdiction that has designed and implemented a safe euthanasia regime, that does not automatically mean that they are unable to answer that question in the affirmative, but they then have a responsibility to set out the parameters, the framework, for which they say it is possible to implement and design a safe euthanasia regime. For reasons that I will outline in a moment, it will surprise no-one, because I have said this previously in this place, that I am of the view that it is not possible—that it is impossible—to design and implement a safe euthanasia regime. Other members may be able to identify a way in which a safe euthanasia regime can be implemented and, if they can, I look forward with interest to hearing what they have to say. At that point, if after wrestling with this process and reasoning through the process they are able to identify a safe way to do this, they have a second question they must consider. They have a duty to answer this second question before they cast their vote in the affirmative: is it appropriate to introduce euthanasia and assisted suicide prior to addressing palliative care accessibility in Western Australia? I will speak more about that later in my contribution today.

It is reasonable to say that there has been a fair amount of discussion outside this house about the decision by my party to appoint me as the lead speaker on this bill. From our party's perspective, there is absolutely nothing peculiar about that. I am the member who has been entrusted with the responsibility of speaking on health portfolio matters and, of course, this government bill was introduced by the minister representing the Minister for Health. I might add that my background and experience on this issue include the following. This is my tenth year in the Western Australian Parliament—a great honour it is to serve in this place—but prior to that my profession was a litigation lawyer. During the course of that time I had to deal with a number of areas of law that are pertinent to the

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matters before us for consideration. One of those areas was medical negligence law, and I will speak about that more in due course. The other area pertinent to our consideration is contract law and, again, I will discuss that in due course.

In addition, as I outlined earlier, this is not the first time a bill of this sort has been before the house. When the last bill that was brought forward by Hon Robin Chapple was defeated I recall saying to some of my colleagues that there was something a little dissatisfying about defeating the proposal of a person who brought it to the house out of good intent and in good faith. I know that the views held by the honourable member are held in good faith. There is something a little dissatisfying about defeating a proposal that is otherwise intended for the good. I asked some colleagues what we could do collectively in a positive sense on a bipartisan or tripartisan basis. The answer to that was the formation of the Parliamentary Friends of Palliative Care. It is a position I have held effectively since shortly after the last debate and it is an honour for me to have been able to do that with my co-chair, the member for Girrawheen and learned friend Hon Margaret Quirk, MLA. During that time we have had the opportunity to organise briefings for members on a range of issues dealing with palliative care.

I will speak more about that in a moment but, in addition, I have served, on behalf of this chamber, on the Joint Select Committee on End of Life Choices, which the government has indicated is the foundation stone of the bill before the house. I note for the record that, of the eight people who served on that committee, I was the only member who attended every meeting and every hearing over the course of that 12-month inquiry, and the outcome of that was the 248-page minority report that members have available to them. In addition, during that time, I was also the co-chair of the Select Committee on Elder Abuse, and I will have more to say about the intersection between elder abuse and the bill that is before the house in due course. That is the background and experience that I bring to this matter, and I am honoured that my colleagues have entrusted me to be the lead speaker on this bill.

The other point that I make is that there has been what I would describe as an element almost of hysteria about the quantity of time that I might possibly take in debating this bill. For that reason, today I deliver my speech, as we would say, *ex tempore*, and not in a wholly prepared fashion, because I want to put to bed any suggestion that any tricks will be used by any members, least of all me, on this matter. Members of this chamber who are familiar with another debate, in which a different approach was taken, will know full well what the outcome of that particular legislation has been to date, and the reasons for it, and that this is an entirely different debate.

As I indicated, I was a member of the Joint Select Committee on End of Life Choices, an inquiry that lasted for 12 months. I recall some of my colleagues asking me at the time why I would bother to serve on that committee. I indicated that I was in favour of the establishment of the committee, because it was looking into end-of-life choices for Western Australians and, as co-chair of the Parliamentary Friends of Palliative Care, I knew then, and I am even more convinced now, that there is a great need to improve the accessibility of palliative care in Western Australia. If I could serve on a committee that would make findings and recommendations to that effect, it would be an honour to do so. Members may recall that, when that committee was formed, in August 2017, I moved for the terms of reference of the committee to be extended. The proposal had been put forward by members, in good faith, seeking the establishment of the committee, and I simply asked that the terms of reference of the committee be extended for this purpose. If the committee was going to look into this issue, I said it should look into the risks of establishing voluntary euthanasia and assisted suicide. I was simply seeking to add one extra term of reference for the inquiry. That proposal was defeated. It struck me at the time that a minister of the Crown urged members to vote against my proposal that the committee that ultimately tabled this report would look into the risks of voluntary euthanasia and assisted suicide. I ask members to examine their consciences and ask themselves why a minister of the Crown would not want the committee to look into the risks of voluntary euthanasia and assisted suicide.

In the same debate, which is the genesis of the bill before us, another member who subsequently served on the committee with me made a very good point. That member said they did not think it was necessary to add this term of reference, because the existing terms of reference would already allow the committee to examine the risks of voluntary euthanasia and assisted suicide. What that member said was true in theory but proved to be false in practice. It is a point of enormous exasperation that the Parliament has entrusted a committee to examine end-of-life choices for 12 months, and that committee has not looked into the risks of establishing voluntary euthanasia and assisted suicide. If members want to disagree with me on that point, during their contributions they need to turn to the pages and paragraphs in the committee's report that examine the risks of voluntary euthanasia and assisted suicide. Members will take a very long time looking for it; it does not exist. That is precisely why there is a 248-page minority report—something that I understand is unprecedented.

I have no problem with people of good faith putting forward a proposal suggesting that Western Australia should join the very small number of jurisdictions that have allowed euthanasia and assisted suicide. However, if they are going to do that, as has already been indicated, it needs to be done in a respectful and honest fashion. I am honestly asking members why the foundation stone for this bill before the house would be an inquiry that did not look into the risks of establishing voluntary euthanasia and assisted suicide.

In addition to that, one of the terms of reference that was granted to the committee by the chamber was to look at the intersection with federal law. There was a specific term of reference that the Joint Select Committee on End of Life Choices should look into the intersection with federal law. Again, I ask members to examine their consciences and reason through this process and identify the page number in this report by the committee where that has been done.

There is so much more that I would like to say about the conduct of that inquiry, as the only member of the eight who attended every meeting and every hearing. There was not even a staff member who lasted the entire inquiry. I am the only person who started from the beginning and attended everything until the end. There is more that I would like to say about the inquiry but, as we know, a decision has been made not to release the minutes of that inquiry. It is a debate that we have had previously, and I have indicated that, for the reasons I have mentioned previously, that is unusual and unnecessary.

I turn to the first question that I have asked members to consider during this debate; that is, is it possible to design and implement a safe euthanasia regime? In order to answer that question, we first of all need to define what is safe. If we are going to ask the question whether it is possible to design and implement a safe euthanasia regime, we first need to agree, or at least discuss, what we mean by safe. I have heard in this place, and in the other place, and from people in the community, talk about the need for safeguards, so that seems to me to be an indicator that there is a broad consensus that if a regime is to be brought in, it needs to be safe. What is safe? In order to answer that question, members will need to be able to determine what is the acceptable casualty rate. I say, at the outset of debate that, for me, the answer is zero. That is not a particularly unusual position to take. I remind members, and I am sure they have seen it themselves, that there is an advertising campaign at present dealing with road safety. Members will recall the vision of the gentleman in the advertisement who is asked effectively what would be an acceptable casualty rate, or words to that effect. As I recall the ad, he talks about a figure in the region of 70, I think it is. However, when he sees his family coming around the corner and realises what 70 means in practice, he changes his mind and says that the acceptable casualty rate is zero. I hold that same view on this issue. I know from the research that I have conducted into this matter over the last 10 years that to design and implement a safe euthanasia regime is a legal impossibility. Again, that should not really surprise us as we examine our conscience and reason through this process. It is for exactly that same reason that Western Australia does not allow capital punishment. The community has determined that despite all the safeguards in the criminal justice system, we are unable to give effect to the aspiration that the acceptable casualty rate is zero. The community believes that the safeguards in our criminal justice system are inadequate to justify capital punishment. That is because we know that there will be a casualty rate.

I now want to take a moment to compare and contrast the safeguards in the criminal justice system with the safeguards in this bill. It has been suggested, in a very overt fashion, that the bill contains some 102 safeguards. That is false. There are not 102 safeguards in this process. I will give members an example. It has been suggested that a person will be able to access this regime only if they have been given a prognosis of six months to live. That is not a safeguard. That is a requirement. There is a difference between a requirement and a safeguard. The truth is that the only safeguard in this legislation is the two doctors who will determine the outcome. Neither of those doctors will be required to have any specialty or experience in the condition that the patient is said to have. Therefore, it could well be two general practitioners. That is the only safeguard in the bill before the house.

I compare and contrast that with the criminal justice system. I put to members that the criminal justice system contains a plethora of safeguards. The community has determined that those safeguards are inadequate to justify capital punishment. I ask members to consider those safeguards and whether they could be implemented into this proposed regime. The criminal justice system begins with a complaint. The independent office of the Western Australia Police Force is charged with determining the extent of the investigation of the complaint. During the course of the investigation, WA police can call in and interview the suspect. The suspect is required to give only their name and address; other than that, they can stay silent. That is the extent to which they have to cooperate with the investigation. Western Australians are very concerned about the possibility of abuse in the criminal justice system. Therefore, we ensure that any person who is subject to an investigation by WA police is supported by a legal expert, who is taxpayer funded, through legal aid if necessary. If it is a particularly heinous crime and the police decide to lay charges, the police do not prosecute the case. We implement another safeguard by ensuring that the independent office of the Director of Public Prosecutions prosecutes the offence. The Director of Public Prosecutions is obliged to reveal all the evidence, including evidence that might assist the suspect. The suspect is provided with legal representation throughout that process. After that independent investigation and independent prosecution, the final decision is made by another group of independent people—namely, the jury. In Western Australia, the suspect does not need to have a reason to object to a proposed juror; the suspect can object just because they do not like the look of that person. That is another safeguard to ensure that the independent investigation is followed by an independent prosecution and is decided by an independent jury. A specialist in the law, namely a judge, acts as umpire to ensure that everybody follows the rules and nobody abuses the safeguards that are in place. The community of Western Australia has determined that even though all those safeguards are in place, if a guilty verdict is handed down, there may be the possibility of casualties; therefore, we will not allow for capital punishment. An additional

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safeguard is that people are allowed to appeal to the High Court, if necessary. Throughout this process, the prosecution is required to prove the case not on the basis of any old evidence, and not on the balance of probabilities, but beyond reasonable doubt.

I ask members to compare and contrast that plethora of safeguards with two general practitioners signing off on voluntary assisted dying. In due course, members may put to me that there is a distinction. Members may say that it is not right to talk about the safeguards in the criminal justice system, because that is the equivalent of involuntary euthanasia—of course the suspect did not volunteer to be investigated and prosecuted. I want to tease that out in two ways. First, I remind members that it is not outrageous to compare and contrast the two. It is possible, and has happened, that a suspect pleads guilty. If a person pleads guilty, despite all the safeguards that are in place, we would be pretty confident that the person was guilty. We need to remember that the person is entitled to be given taxpayer-funded independent legal advice, and to be independently investigated. I remind members that in this fortieth Parliament, the Joint Standing Committee on the Corruption and Crime Commission, of which Hon Alison Xamon and Hon Jim Chown are members, tabled a report dealing with the case of Mr Gibson and the unlawful death of Mr Warneke. In that case, the suspect pleaded guilty. We now know that that was wrong. Thank goodness that despite all the safeguards in the criminal justice system, we do not have capital punishment in Western Australia; otherwise that particular individual would have been executed. This person had pleaded guilty. Therefore, members, please do not say to me that this situation is different, because this is voluntary euthanasia. I do not know how many times during this debate emphasis has been put on the word “voluntary”. Let us have a debate about what “voluntary” means. It is all very good for us to use the language, but what does it mean in practice?

For there to be a valid consent—this is a legal principle—three elements have to be present. Firstly, the person has to have capacity; secondly, they must have knowledge of the matter to which they are consenting and agreeing; and thirdly, there needs to be a voluntariness of their decision. These legal principles apply in every other situation, and they also apply in a voluntary assisted dying regime. These are fundamental principles of law.

What could possibly go wrong in this situation? I ask members to consider the lessons that can be learnt from medical negligence. Members will be aware that medical practitioners in Western Australia are obliged to hold medical indemnity insurance. Why is that? It is because doctors make mistakes. I would be reasonably confident that most members in this place, if not all members, would know of a doctor who made an error in diagnosis; in other words, they told the patient that they had a particular condition only for that later to be found not to be true.

Something fascinated me, and I have still never really understood why it happened. As I say, I am still somewhat constrained in what I can say about the conduct of the inquiry. A case has been hidden from members in the committee report, but it is found and referred to in my minority report. I cannot answer the question about why this case was hidden from members in the committee report, but it was the case of an individual who had been told that they had a terminal condition only for that not to be true. This individual was then sent on a course of palliative care treatments only for those later to have been found unnecessary. That is just one of dozens, if not hundreds or thousands, of examples of an error in diagnosis, as happens from time to time. It will require only one error in diagnosis under this legislation by those general practitioners, or whoever the two doctors involved are, for there to be a Western Australian casualty. We know that has happened in the other jurisdictions.

Medical negligence law is not simply limited to errors in diagnosis. There will also be errors in prognosis. The bill before the house contemplates a doctor coming to a decision, a consideration, that the person has six months or fewer to live, and in certain circumstances that is extended to 12 months. Could a doctor say a person has six months to live only for that not to be the case? Have members ever come across that situation in which a person has been told that they had six months to live, but in actual fact they had many more years to live? That is what we call an error in prognosis. The medical profession accepts that practitioners routinely make errors in prognosis, yet it will require only one error in prognosis by the two safe-guardians under this legislation for there to be a Western Australian casualty.

Another matter I ask members to consider while we are thinking about the impact of medical negligence law in any voluntary euthanasia or assisted suicide regime is the existence of doctor bias. Some proponents will say to us that it is okay, because we can trust the two doctors who have to make this decision. Could the doctors who have been entrusted with this task and duty have a bias towards voluntary euthanasia and assisted suicide? We already know that in Western Australia we even have at least one doctor who, if you like, boasts about her treatment of some patients at end of life and how it has been inconsistent with the laws of Western Australia. She then says that is the reason that laws need to change. Are these the people whom we will trust to make these decisions? In a moment I will talk more about the Northern Territory experience, where there is a doctor with a very well known and overt bias for euthanasia and assisted suicide. Could those doctors who have a bias steer patients towards this outcome? That is all that needs to occur for there to be Western Australian casualties at the end of this process.

The other lesson I have learnt from my experience in practising medical negligence law is the ease by which doctor shopping occurs. The so-called safeguard in this legislation is that two doctors will have to agree. Members, in my previous profession, it was routinely the case that people could shop until they got the opinion they needed from

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a doctor to support their case. Doctor shopping occurs routinely already, and this will be the easiest and simplest way to pierce the veil of the safeguard. If the safeguard is two doctors, GPs or otherwise, a simple excursion of doctor shopping will pierce the veil of that safeguard.

I now turn to consider the lessons we can learn from contract law that teach us that it is impossible to design and implement a safe euthanasia regime. Two of the contract law principles that confirm that for us are duress and undue influence. I want to give a couple of examples. My learned friend Hon Pierre Yang, who is a former family lawyer, has more experience in this field than I do, but he, and perhaps others who have practised in family law, will be familiar with binding financial agreements. Binding financial agreements were previously referred to as prenuptial agreements. In law, if a person enters into a prenuptial agreement under duress or undue influence, after the event, the courts will set aside that agreement and say they will not allow the terms of that binding financial agreement to be adhered to because it is wrong that the person entered into it under duress or undue influence, or maybe some unconscionable conduct was involved. This happens, and we have had cases, including in the High Court of Australia, setting aside those types of agreements.

In this instance, there will be a contract between a doctor and a patient. Unlike a binding financial agreement, if that contract is entered into under duress or undue influence, it will be a legal impossibility for that person to claim redress after the event. This situation in contract law is not simply limited to these family law agreements. Indeed, I remind members that banks routinely require people to sign guarantees. If those guarantees have been entered into under duress or undue influence, courts will not hesitate to set those guarantees aside. It is all well and good when we are talking about binding financial agreements, bank guarantees or other forms of contract to be able to provide some redress and restitution to a person who has been wronged, but it is impossible to do that for a dead person. It is the case that if a Western Australian enters into a voluntary assisted dying regime under duress or undue influence, they will be a casualty as a result of the legislation before us. It is yet another example, just like those in medical negligence law, that tells us why this type of regime ought to always be prohibited, because it is an impossibility to design and implement a safe regime.

I pause for a moment to consider: what impact does the existence of elder abuse in Western Australia have as we contemplate the particular regime that is before us? As I indicated at the outset, during effectively the same 12 months that I served on the Joint Select Committee on End of Life Choices I also served on the Select Committee into Elder Abuse. One of the many things that inquiry into elder abuse found is that different forms of elder abuse take place. Psychological and emotional elder abuse is in competition for top ranking with financial elder abuse as the most prevalent form. That was the consistent evidence the committee received in that 12-month inquiry. I encourage members to look at the report to that effect.

Contemplate for a moment what that means. If psychological and emotional elder abuse is prevalent in Western Australia, how easy is it for a person to be steered towards a voluntary assisted dying decision in circumstances of psychological and emotional elder abuse? This is why I have said previously that this notion of steering is the elephant in the room. We need to intellectually wrestle with that realisation as we consider this bill and reason our way through that process. This is one of a number of reasons why I say to members that it is impossible to develop, design and implement a safe euthanasia regime when lessons in medical negligence law exist, when we know about the contract law principles and when we know that psychological and emotional elder abuse is prevalent in Western Australia.

Members who may be familiar with my minority report will know that it has three chapters. The first chapter looks at current end-of-life choices in Western Australia, including palliative care. The second chapter looks at the theory; that is, what are the risks in implementing a euthanasia or assisted suicide regime—that very thing that I asked the committee to be particularly mindful of? Incidentally, if someone later, during the course of the debate says, “We did look at what happened in other jurisdictions”, what they really mean by that is that we looked at the legislation. It does not mean that we looked into any of the wrongful deaths in those jurisdictions; we simply did not do that. That is evident from the content of the report. It is not the case that we took evidence from those in international jurisdictions with respect to wrongful deaths—no, not at all. I will give members an example. When the committee looked at the Swiss model, who did we call? We called Dignitas, which comprises individuals who execute this act in Switzerland. When the committee was looking at the Northern Territory experience, we spoke to Dr Philip Nitschke and to the then Chief Minister, who was a proponent of the legislation. That is the true extent to which we looked at the wrongful deaths in the other jurisdictions during a 12-month inquiry.

As I say, the second chapter of my minority report looked at the theory; that is, the different risks that could occur—the thing that the committee did not want to look at—but then I finished the minority report by looking at the lived experience in those other jurisdictions. I ask members to turn their mind to this: to what extent, before we pass this particular piece of legislation, do we have a duty to consider the lessons from those other jurisdictions? Members might say to me that it is all well and good to talk theory but we want to know about the real experience. What has actually happened in the few jurisdictions where this has occurred? That is what chapter 3 of my minority report was devoted to. It is the case that when one looks at the European experience, for example the Netherlands, my general practice is not to try to debate with members on matters that are necessarily in contention—I am quite

happy to have a minimal facts approach to this—in other words, what matters are simply undeniable? There is often a discussion around the “slippery slope” and whether it exists and so on and so forth. I say that that is just a red herring; let us not even bother having that discussion.

Let us look at the facts in the Netherlands. It is a fact that there has been an incremental expansion in the practice of euthanasia in that jurisdiction. Whether members want to describe that as a slippery slope is a red herring; who really cares what the description of it is? As we intellectually wrestle through this particular debate and reason through the process, let us ask ourselves whether there has been an incremental extension in the practice in the Netherlands. It is intellectually dishonest to say otherwise. It is no wonder that that is the case because if a regime sets a particular bar and says, “Voluntary assisted dying—euthanasia or assisted suicide—is only going to be available for these particular people”, as this bill does, certain Western Australians will be able to access this particular regime and others will not. It is inevitable that people will want to push up against that barrier. Indeed, I suspect that most members in this place, if not all 36 of us, will have already been lobbied or have had advocacy suggesting that this bill does not go far enough. It is certainly on the public record that proponents have said, “We need to get something through at this particular point.” “It is a good start” is sometimes the language that is used. A start to what, members? Where are we going with this?

This is no mere theory. Firstly, these are the words articulated by proponents in Western Australia; and, secondly, we know from the lived experience in the Netherlands that there has been an incremental expansion in the practice. Because the European experience is often too uncomfortable for proponents to stick with that debate, my experience over the last 10 years has been that we quickly move away from the European experience. Why? Because they have allowed euthanasia for the mentally ill and for children, which makes us uncomfortable. I am thankful that that makes us uncomfortable in Western Australia. What happens as a result of that uncomfortableness is that we quickly shy away from that debate and start to look at other jurisdictions. That is fine. I am the first to accept that is not what the proposal before us is at this time. I simply raise it now because I am sure that it was not the proposal in the Netherlands some 20-plus years ago either. Let us not deny the actual lived experience in the Netherlands and Belgium. I might add that Belgium went one step further than the Netherlands with its legislature changing the law. The Netherlands has continued to incrementally expand the system by way of practice and judicial determination and interpretation. What normally happens then is that it suits proponents to shift the debate. It is very uncomfortable talking about the European experience, so they shift to the North American experience. We have already seen the same push for an incremental expansion in Canada, which has a fairly new system. An election is taking place at the moment and one need only look at the rhetoric in Canada to see that that is what is taking place. In fact, just recently there was a court decision to that same effect looking for an expansion. That does not surprise me because, as I said, if we set a particular bar and say that some Western Australians will be able to access this, we can expect people to continue to push against that bar. Why is it that only some Western Australians will be able to access voluntary assisted dying and not others?

Because the Canadian experience has tended to morph towards that experience in Europe of an incremental expansion, I find that the debating ground that is most comfortable for proponents is the Oregon experience. Usually that is where we end up. Usually people say, “Let’s not talk about the Netherlands anymore. We are too uncomfortable talking about euthanasia for the mentally ill. We’re too uncomfortable talking about the experience in Belgium, which has seen children euthanased. We are not comfortable with what’s going on in Canada because of the very overt expansion of the system. Let us talk about Oregon because it has had decades of experience.” There is the suggestion that its regime is the safe one. Is it? Before members cast their vote in favour of the Voluntary Assisted Dying Bill 2019 on the assumption that the Oregonian experience is somehow safe, they should test it and check whether that is true. They should find out whether there have been any wrongful deaths in that experience. There is no point looking for it in the committee report because not one paragraph deals with the wrongful deaths in Oregon. They will find it in the minority report and I encourage them to look at it. If they do, they will see from the data—not my data, but data from the Oregon Health Authority—that there have been medical errors in prognosis countless times. What does that mean? Under the Oregonian model, it is necessary that there is a prognosis of six months to live before someone can access euthanasia. Why is it then that people have taken the lethal substance sometimes years after the initial prognosis? It is because there has been an error in prognosis. The medical errors in prognosis are there to see in the Oregonian data. We are about to embark upon a similar regime that allows for a prognosis of six months to death. The only rational explanation that we can use to justify that is that Western Australian medical practitioners are magnificently superior to Oregonian doctors in diagnoses and prognoses.

In addition, we know now, as a result of a couple of decades of experience in Oregon, that doctor shopping is frequent—to the point of it now being what I would describe as a commercial exercise. If people do not like a decision, they can continue to shop until such time that they get the opinions they want and can access voluntary assisted dying. Oregon does not have voluntary euthanasia; it has assisted suicide.

The third point I make about the Oregon model and one that I ask members to consider is the complication rates. An interesting element of this debate is it seems that because a medical practitioner is involved and because we

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are talking about the use of a needle or swallowing a poison or substance that somehow we feel that that is a safe regime. There is an excellent line in a documentary entitled *Fatal Flaws: Legalizing Assisted Death* in which a US doctor says something to this effect: “I wonder if the debate would shift if instead of using the needle as a symbol, we used a gun? I anticipate that if we did that, transculturally around the world we would say that that is wrong.” I think he is right on that point. The question that members need to ask themselves is whether it is reasonable to make that substitution. Are we now simply arguing about the method, implement or tool, or are we talking about the risks of what could go wrong? The Oregonian data confirms that there have been significant complications. Sometimes after a person has taken a substance, they have taken days to die, which was contrary to their expectation when they entered into that arrangement and contract with the doctor. That is not my data. Members should check the Oregon Health Authority’s data. That is the complication rate. The complication rates for the use of lethal injections has resulted in some states in the United States of America saying that it is not humane to use that as a form of capital punishment and they have abandoned it. The same thing applies with this issue.

Usually during a debate about the various jurisdictions, I find that what happens is that people in Western Australia, indeed Australia, say, “Look, honourable member. It’s all very good to talk about the Netherlands and the mentally ill and Belgium with the children, the complication rates, doctor shopping and medical errors in prognosis and diagnosis. It is all very well to talk about that but we wouldn’t do that.” That is usually the line that comes out—“We would not do that. We have confidence in the medical practitioners in Western Australia. We hear your concerns, but we don’t think that that’s going to happen in Western Australia.” I ask members to consider the Northern Territory experience. If they do not want to consider the lived experience in those other jurisdictions because they do not think it is relevant—I put it to them that it is relevant—and are in that particular space, I ask them to consider the Northern Territory experience, which saw doctor shopping at its worst. There is nothing in the bill before us to prevent the same thing from happening here. Let me explain that. I will give members one example of what happened in the Northern Territory. A patient had mycosis fungoides, which is a cancer of the blood that affects the skin. In the Northern Territory scheme, a person needed two doctors to sign off on their illness. The first doctor was Dr Philip Nitschke. I leave it to members’ conscience to consider that if Dr Nitschke was the first doctor, how much confidence they would have in the assessment of the first doctor—that everything that should and could have been done was done properly. To what extent will they examine their conscience and say that that particular doctor did not have a bias towards voluntary euthanasia and was not looking to achieve a particular outcome? I leave it to members to consider that. Be that as it may, a second doctor was to be involved. The law in the Northern Territory, unlike our bill before the house, said that the second doctor needed to have some kind of experience or qualification in the underlying condition. The problem for Dr Nitschke, or Mr Nitschke, as he is now, at that time was that the dermatologist and the oncologist would not agree to be the second doctor. Why not? Because the patient was not diagnosed as being terminally ill. The doctor shopping experience then took place and resulted in an orthopaedic surgeon being the second doctor to sign off on this particular patient’s death. For those who are unfamiliar with this, an orthopaedic surgeon has neither the qualifications nor the experience in anything whatsoever to do with mycosis fungoides. This is how it was treated in the Northern Territory experience. We are not talking about the Netherlands, Belgium, Switzerland, Oregon or Canada; this occurred in our country. This is how voluntary euthanasia was delivered in the Northern Territory. Members, ask yourselves why it would be any different in Western Australia. Who is going to be Western Australia’s Dr Nitschke? People with a bias towards a particular outcome will run around and continue to shop until they get the outcome that they want. Why? Because the bill before the house requires only two doctors to sign off on this.

I hope in some way that the explanation I have given over the last 60 minutes or so demonstrates to members why I so passionately say that it is impossible to design and implement a safe euthanasia regime. I say that because of the theory and because of the lived experience. Ultimately, after all that, if members still disagree with me, they still say that there is a safe way in which this can be done and that it is possible, and after intellectually wrestling with the issue and reasoning through it, they can articulate what that safe system looks like and why it is a safe system, and say, “Therefore, we would like to support this”, I move to my second and final question, which is: is it appropriate to introduce euthanasia and assisted suicide prior to addressing palliative care accessibility?

Associate Professor Richard Chye is the director of palliative care at St Vincent’s Hospital Sydney. I have never met this particular doctor but he said something that really went to the heart of this question. According to my notes, he said that no terminally ill Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide. I ask members: Would that not be an interesting proposition for us to vote on? If we substitute the word “Australian” with “Western Australian” and say that no terminally ill Western Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide, how would we vote? I put it to members that that is exactly the question that is before the house now. The question may be whether the bill should be read a second time, but as we examine our conscience on this matter, we need to ask ourselves: should any terminally ill Western Australian ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide?

On what basis do I say that that is the question before the house at the moment? I draw to members' attention the findings in the report of the Joint Select Committee on End of Life Choices. Fear not, I am not referring to the minority report, which the government has not responded to. Not one finding or recommendation of that 248-page minority report has been responded to. I am referring to the committee report. I take members to findings 9, 10 and 11, which deal with this particular point. I emphasise that these are the findings of the committee, not the findings of the minority report. It states —

Access to inpatient specialist palliative care in Perth is limited.

...

Apart from a small number of private beds at Glenngary Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs ...

...

Silver Chain is providing community palliative care to more patients than for which it is funded.

The committee recommends —

WA Health should conduct an independent review, from a patient's perspective, of the three models of palliative care in Western Australia: inpatient, consultative and community. The review should examine the benefits and risks of each model and the accessibility of each across the state as well as the admission criteria for hospice care ...

Where is the independent review, members? The government said that it agreed to the recommendations in this report. We are embarking on a regime that will give Western Australians ready access to lethal injections at end of life. The committee has made these findings and has recommended that WA Health conduct an independent review from a patient's perspective. Where is the report on the review? I note that the committee then goes on to say, in findings 12, 13 and 14 —

Access to specialist palliative care in the early stages of a diagnosis might improve remaining quality of life, mood, resilience, symptom management and allow for death in the patient's preferred location. These benefits would be more readily available to patients if difficult discussions about death and dying took place earlier.

...

More can be done to promote understanding of palliative care in the community and with health professionals to ensure that more non-cancer patients who could benefit from palliative care are receiving it.

...

There is inconsistency in the data regarding the number of patients with conditions amenable to receiving palliative care. This is perhaps reflective of the uncertainty regarding which diseases or conditions are appropriate for palliative care.

As a result of those findings by the committee, not the minority report, it makes these two recommendations —

WA Health should implement a process to determine the unmet demand for palliative care and establish an ongoing process to measure the delivery of palliative care services with the aim of making those services available to more Western Australians.

Has it been done? Recommendation 11 states —

To improve understanding of palliative care in Western Australia, WA Health should:

- establish a consistent definition of palliative care to be adopted by all health professionals;
- provide comprehensive, accessible and practical information and education services about palliative care to health professionals and the community;
- encourage knowledge sharing by palliative care specialists with their generalist colleagues; and
- establish a palliative care information and community hotline.

What is the number of the hotline, members? They are not my recommendations; they are not my findings. They are the findings and recommendations of the Joint Select Committee on End of Life Choices. This is the foundation stone for this bill. This is what the government has said it has agreed to. Do we have answers to these questions before we lead the community to having ready access to lethal injections?

I return to my original question: should terminally ill Western Australians ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide?

Finally, on this point, I note that findings 16 to 20 state —

Access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients.

...

Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population.

...

There is a gap in care for people who are seriously unwell but not close enough to death to be admitted for inpatient hospice care.

...

There is limited access to palliative care medical specialists in regional Western Australia.

...

There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Services.

The committee makes three recommendations about palliative care. Recommendation 12 states —

The Minister for Health should prioritise policy development and improved governance structures for the delivery of palliative care by WA Country Health Services.

Has that been done? What is the new governance structure? Recommendation 13 states —

The Minister for Health should ensure regional palliative care be adequately funded to meet demand.

It concludes with recommendation 14, which states —

Once a consistent definition of palliative care has been established by WA Health in accordance with Recommendation 11, the Minister for Health should appoint an independent reviewer to audit:

- The level of palliative care activity actually provided in Western Australia's hospitals and compare it against the level of recorded palliative care activity.
- The actual spend by WA Health on palliative care on a year-by-year and like-for-like basis, across all aspects of palliative care provision, including community service providers, area health services (including WA Country Health Services) and delineating between inpatient, consultancy and community care.

Has that been done? What is the name of the independent reviewer?

If none of those things has been done because the government has instead decided that since that report was tabled in August last year, over the following 14 months the higher priority has been this legislation before us, that is wrong. As I suspect, when most members examine their conscience, they would feel very uncomfortable if any Western Australian should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted suicide. It is in this context, not in respect of my findings and recommendations in the minority report, but in the committee's findings and recommendations on palliative care—findings and recommendations that the government has accepted—that I ask: how can it be appropriate for us to introduce voluntary assisted dying, whether we want to describe that as voluntary euthanasia or assisted suicide or otherwise? In many parts of Western Australia, this will mean no real choice at all.

I conclude with these five statements. Firstly, the desire of a significant proportion of confident people for ready access to lethal injections ought never override the rights of the quiet vulnerable to safety and protection. I feel sufficiently passionate about that to say it again: the desire of a significant proportion of confident people, confident Western Australians, for ready access to lethal injections ought never override the rights of the quiet vulnerable to safety and protection. Secondly, if we are intellectually honest and reason through the theory of a euthanasia regime, we should conclude that it is inherently unsafe. The insufficiency of the criminal justice safeguards informs us of this. The prevalence of medical negligence informs us of this. The ease of doctor shopping informs us of this. The existence of elder abuse informs us of this. The reality of doctor bias informs us of this. Thirdly, when we engage with the lived experience of the few jurisdictions that have legalised euthanasia or assisted suicide, we know that the theory of an inherently unsafe regime has resulted in casualties of wrongful deaths. In other words, the theory has translated into practice and wrongful deaths have ensued; there have been casualties. Fourthly, there is another way; there is a better way. There is a safe approach to end-of-life choices; however, it will require all of us to persistently insist that quality palliative care is made available to every Western Australian and that until we, the 36 of us, have exhausted ourselves in fulfilling this duty, we should not contemplate a euthanasia regime, let alone this bill, which is more dangerous than the Victorian legislation and more dangerous than the now inoperative Northern Territory legislation. Finally, I oppose this bill because the risks in legalised assisted suicide are simply too great, not the least of which is because the consequences are final.

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**HONSUE ELLERY (South Metropolitan — Leader of the House)** [3.35 pm]: I support the Voluntary Assisted Dying Bill 2019. The questions that each of us need to satisfy ourselves about are actually going to be different. The questions Hon Nick Goiran posed that he wants to be satisfied about or the questions that he suggests we need to satisfy ourselves on are different from the ones I need to satisfy myself about. For me, it is about this: do we agree that for those Western Australians already diagnosed with a terminal illness, who have between six and 12 months to live, we provide a medical and legal framework for them to determine the timing of their death? For me, this is about people who are already dying. Hon Nick Goiran also invited us to block out the noise as we proceed to get on with this. I urge members to listen to and manage that noise, because that noise is democracy and Western Australians want voluntary assisted dying.

The principles and precise safeguards that are set out in the bill before us provide the safety net that members of the community would rightly expect to be part of any legislation on this matter. They are found in part 1, division 2; in the interpretation provisions in part 1, division 3; in the operational provisions in parts 2, 3 and 4; in the review provision in part 5; and in the offences in part 6. A number of safeguards have already been canvassed in the public debate. For me, some of the most important ones are around access: that the request for access is voluntary and without coercion; that it is restricted to those who have reached 18 years of age; that it is restricted to those who meet specific residency requirements; that it is restricted to those who have decision-making capacity for voluntary assisted dying; and that it is restricted to those who are diagnosed with a disease, illness or medical condition that meets a specific and limited set of criteria.

With regard to the request process, the person must make three separate requests. Requests must be initiated by the person themselves, and requests must be clear and unambiguous. Requests cannot be made by a substitute decision-maker. Requests cannot be included in an advance health directive. The person must make a written declaration of the request with two witnesses present. The witnesses must not be beneficiaries, must not be family members, and must not be either the coordinating or consulting practitioner for the person. The person has no obligation to continue and can withdraw at any point in the process. Eligibility is assessed by medical practitioners. The person must have two assessments of eligibility undertaken by separate and independent medical practitioners and assessing medical practitioners are restricted to those who meet the specific registration and experience requirements. The coordinating medical practitioners must complete a final review that confirms that all eligibility criteria and process requirements have been met. The State Administrative Tribunal can review certain decisions. The Supreme Court's jurisdiction remains preserved and health practitioners may refuse to participate in voluntary assisted dying.

The majority of Western Australians have expressed the view that they want voluntary assisted dying legislation; they say yes. They have told us that, as their representatives, they want us to legislate to that effect. They are also telling their doctors, nurses and other health professionals. They are telling the media; they are telling their families, their children and grandchildren. They are telling palliative care providers. They are telling their neighbours and their friends. They are having conversations. They told me at a forum that I held, and I will talk about that in a minute. Complete strangers have come up to me at my local shopping centre and said that they want me to vote yes. In the conversations I have had, many people have expressed surprise, and, I guess, some frustration, at the public commentary that there may be enough members in this chamber who do not support the principle of voluntary assisted dying, or who do not support the detail of this bill, to mean that the majority of the chamber may vote against the bill, despite the clear will of the majority of Western Australians. I think Western Australians are fearful that the opportunity might be lost.

I want to touch a little on some of the measures of public opinion on this matter. Members will be well aware of the article in *The West Australian* of 26 August this year referring to a poll that the newspaper had conducted. It stated —

Nine out of 10 West Australians support euthanasia and the State Government's bid to legalise voluntary assisted dying, a poll conducted exclusively for *The West Australian* reveals.

...

The survey of 656 people, conducted by Painted Dog Research's Social & Health Unit in co-operation with [rewardingviews.com.au](http://rewardingviews.com.au), found 88 per cent of them back voluntary assisted dying and the Government's Bill to legalise it.

...

Only 12 per cent of people said they did not support the voluntary assisted dying Bill.

An overwhelming 93 per cent of people aged 50 to 59 said they would want to be allowed to end their own life with medical assistance if they were terminally ill with a condition causing intolerable suffering.

That particular age group is where I sit, and I think the number is so high in that group because of what I know about my generation. We are assertive consumers of all services, and we want to be in control of everything to do with how we live our lives and, indeed, how we end our lives. Over the years, many polls have been taken, and I will refer to some taken over the last 10 years. In 2016, in the ABC Vote Compass, on the question of whether

terminally ill patients should be able to legally end their own lives with medical assistance, 75 per cent said yes. In 2015, an Ipsos MORI poll asked what people thought of doctor-assisted dying. They were asked whether it should be legal for a doctor to assist patients aged 18 or over to end their life, if that is the patient's wish, provided that the patient is terminally ill, when it is believed that they have six months or less to live, are of sound mind and express a clear desire to end their life. In response to that, 73 per cent said yes. I can go back further to Newspolls over the years. In 2012, the question was: thinking about voluntary euthanasia, if a hopelessly ill patient experiencing unrelievable suffering, with absolutely no chance of recovery, asks for a lethal dose, should a doctor be able to provide a lethal dose? Of those asked that question, 82.5 per cent said yes. I could go back to the Newspann in 2007 on the same question. On that occasion, 80 per cent said yes.

The detail of the medical and legal framework will be examined in detail, and I urge all members who support the principle to work together to ensure that a bill is passed by December that gives real effect to that principle. To those who do not support the principle, I respect that, and it is their right, and indeed their obligation on behalf of those in the Western Australian community who share their opposition, to oppose the bill. If members believe that no matter what changes are made to this bill they will never support it, I ask them to make a judgement call about the point at which, and how, they demonstrate that they also respect the majority view of Western Australians. Please do not misinterpret this as me disrespecting every member's individual conscience vote on this bill, and every member's right to satisfy themselves on the detail of the bill—I do absolutely respect those rights. But I have been a member of this place for 18 years, and I have been the Leader of the Opposition. I have seen used, and have used myself, every procedural method to delay a bill that I want to oppose. I know how to slow down the committee stage to the point that no or limited progress is made. I know how to ask for information that is actually irrelevant and will not change the way that I vote. I know how to refer a matter to a committee when in fact nothing that the committee recommends will change how I vote on the second or third reading.

I just make the point that, unlike much of the legislation to which I have applied those tactics, the genesis of this bill has been an extended and extensive period of public consultation and debate. The genesis and development of this bill so publicly has meant that every stakeholder with a view has been able to get those views to each of us, whether by the hundreds and sometimes thousands of emails sent and received, other correspondence, face-to-face briefings or meetings, the range of seminars organised by various proponents, or other forms of representations and forums. Any of us wanting additional information have been able to find stakeholders of all persuasions to assist us. Ultimately, the 36 of us in this place with a vote will have to decide ourselves. We have to weigh up the advice that we sought ourselves, that we were provided with, or that we stumbled across. There are experts on both sides of the debate, good people who hold genuinely formed views, who can assist, hinder or confuse, but ultimately our democratic system says that it is down to us. Procrastinate or not, filibuster or not, we still have to make the decision ourselves, and our community is saying yes, and asking us not to delay.

My motivation for supporting this bill exists at several levels. Firstly, I guess, it is for myself. Not unlike many of my generation, I want to be in charge of my life and I want to be in charge of my death. I want to know that I have the choice. I have spoken before on legislation in this policy area, and I said then, and I will say again now, that if I find myself in a position in which this legislation applies, I do not know what I would do and I do not know what choice I would exercise. Knowing my personality, I may well fight, fight and fight to stay alive. But if I know death is inevitable, I may well want to know that I have the choice to exercise the timing of my death. I may well exercise it, and I may well not exercise it, but I want to know that I can.

I am also highly motivated by the experience of others, most recently that of my friend Deborah Walsh, who died on 20 October 2017. Some members may have known her father, the late Senator Peter Walsh, who was the federal Minister for Finance in the Hawke government. Some members may know her husband, Gary Gray, who was national secretary of the Australian Labor Party and a former member for the federal seat of Brand. I knew Deb for the person she was in her own right. Deb and I were foundation members of the highly unimportant cross-factional redheads caucus. That was started in the early and mid-1980s when factions were formalised in the WA Labor Party. Deb, Ruth Webber, Deb's sister Anne, a few token blondes in Kate Ellis and Lois Anderson, and I used to meet in the Court Wine Bar after state executive meetings. We provided character analysis of those we liked and the many we did not like. We drank a lot, we resolved much, but none of it related to anything of significant political standing, and we did not influence a single preselection, but we enjoyed ourselves. We told great stories, and some of them were occasionally true. We took the proverbial out of the many terribly, terribly self-important blokes who were around us at the time.

Eventually, our lives took their inevitable different paths career and family-wise, and we all moved on, crossing paths every now and again. For example, I was at Deb's wedding to Gary. Two years ago this month, I saw some of those people at Deb's funeral. She was 54 when she died, following breast cancer. In August 2017, Gary rang me to tell me that Deb's time was limited. They had been told she might last until Easter 2018. They were hoping she would last until Christmas 2017. Deb wanted the opportunity to make a submission to, or even appear before, the Joint Select Committee on End of Life Choices. I was keen to help Deb do that if I could.

However, she did not get the opportunity to do that, because although her mind remained sharp to the end, she was physically frail. She was militantly in support of legislation to give effect to real choice for people with a terminal illness.

In preparing my speech for today, I asked Gary whether I could refer to Deb's views and circumstances. A few weeks ago, I caught up with him to take some notes. I want to thank Gary for sharing with me what was, and remains, obviously, a very significant tragedy in his life. This is what he told me. In early October 2017, Deb made the decision that no more investigations and invasive procedures would be conducted. She was strong in mind, but physically frail. She put Gary in charge of her dying, and she put her sisters, her mother and her friends in charge of her living. It was a constant open house and party. She picked the coffin. She picked the funeral proceedings. She wanted only the boys and Gary to speak. She was very, very strongly in favour of voluntary assisted dying. She wanted a system that would work. She had watched her sister deal with her father's death, and she had watched Gary deal with his father's death. She saw and was of the view that voluntary assisted dying laws would provide a map and a pathway for everyone. Her biggest fear was a painful death, and that it would be painful for her loved ones and might have a damaging impact on her boys. She was the mother of three sons. She could see how death could break some people, and she could see how death could make others stronger, but only if it was managed well. In the hospital, she had really good people look after her and her family. Those good people, including oncologists, were confident that she would live beyond the time that she lived. The night before she died, her oncologist said to her, "I'll see you in the morning." Deb said, "I don't think I'm going to be here past tonight", and she was not. She died at 7.50.

Deb wanted to give evidence to the committee, and I gave her, through Gary, a commitment that I would do whatever I could to help her do that. However, in the end, she could not do that. Therefore, I wanted to make these comments in my speech to honour my commitment to her, and to use her example to demonstrate to members why I so strongly believe that this is important legislation that needs to be passed.

When Deb died, her three sons were holding her. Her mum was holding her hand. Her sisters were around her. Gary was in the room, within her line of sight. Gary said that she wanted to express the view that the system as it is now is not an evil system. He said that she would have wanted me to express the view that there were thoughtful, courageous, caring, kind and highly professional staff who worked really hard to keep her alive. At the end, she had managed so well that she had the capacity to know when she wanted to let go, and she did. She knew how to be her own best advocate, but she also knew that plenty of others could not.

Deb's death was beautiful, gentle and easy, and support was provided for those around her. One of the most poignant things that Gary talked about was the level of her decision-making. She had asked one of her nieces to paint the coffin that she would be taken out in. Equally, a kind of maturity, I guess, was exercised by her sons, the youngest of whom, Toby, was only 14 or 15 at the time and in year 10. The boys made the decision to carry their mother's coffin into and out of the service, because they wanted to physically feel her weight in that coffin. Gary said that Deb did all the planning that needed to be done, with humour and good grace. She was bossing Gary to the end, and then she let go. She was gracefully in control, she was powerful and she was generous. But our culture does not do death well, generally. Deb wanted to know that everybody would be given the opportunity to exercise control and make decisions about how their last days, weeks and perhaps months, would be spent.

It is interesting that as part of the public debate, we have heard from health professionals on both sides of the argument. We have heard from two of the largest groups—nurses, through the Australian Nursing Federation, have publicly expressed their support for this legislation, and the Australian Medical Association, representing doctors, has taken an opposing view.

When I was deciding what I would rely upon in my comments, I read a lot of material. Some of that material came from the voluntary assisted dying debate in Victoria. I refer in particular to a document titled "Assisted Dying: Setting the Record Straight." It provided a summary of some of the issues raised in the Victorian parliamentary inquiry. I thought it summarised those issues quite well, as did our own parliamentary inquiry here. It crystallised for me that every year, and in fact somewhere in Western Australia right now, families are struggling with how to best manage the end-of-life choice of one of their loved ones. Every year, desperate terminally ill Australians are ending their own lives, often in horrific circumstances. Some of the circumstances that were provided to the Western Australian parliamentary committee inquiry demonstrated that families are being traumatised after witnessing the bad deaths of loved ones.

Some of the mythology, perhaps, that has been expressed during the course of the public debate is that predicting whether someone is expected to die within a specified time is not entirely accurate and therefore we should not rely on doing it at all. "Terminal" is already a legally recognised term in Australia. Insurance companies accept the prognosis of a certain period of time for the payout of a life insurance policy. It is a longstanding practice and has been considered uncontroversial.

**Extract from Hansard**

[COUNCIL — Tuesday, 15 October 2019]

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President; Hon Nick Goiran; Hon Sue Ellery; Hon Peter Collier

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Palliative care has also been raised in the course of the public debate. Palliative care in Australia is among the best in the world, but more can always be done. However, the argument I do not accept is that we can only move to consider voluntary assisted dying if we get palliative care to some unspecified point that meets someone's criteria—their version of palliative care as the best it can be. I have seen palliative care work fabulously for a friend of my husband's and mine, and for family members, but palliative care cannot deal with pain and suffering for everybody. No matter how much money we put into the operation of palliative care as it operates now or even into research for better palliative care, it cannot meet the requirements of everybody. I think it is possible to chew gum and walk at the same time. It is possible to improve palliative care and provide additional resources, while at the same time putting in place a legal and medical framework that gives effect to voluntary assisted dying. It is not the case that we must do the first before we can do the second. I do not accept that argument, and I do not accept that most Western Australians accept that argument either. Not all terminally ill people view palliative sedation, whether it relieves the pain or not, as a satisfactory alternative to being able to make decisions themselves in those circumstances about the timing of their death.

The point I made earlier about what I might choose to do was I think well illustrated by Andrew Denton. In 2016, he made a speech at the National Press Club. In his investigations, when he looked at policies that applied in other jurisdictions, he described discovering a golden rule that applies the world over; that is, most people do not want to die. They will do just about anything to stay alive, to be with family, to celebrate a grandchild's birthday or to wake up and marvel at the beauty of the sunrise, and I agree with that. I also think people want control and choice. The conclusion Andrew Denton reached was that if we do not give them that control and choice, desperate people will take desperate measures, and that people are dying awful, awful deaths when their deaths could be so much more dignified.

This debate has also been good because it has raised the issue of how we deal with death more generally. I refer to the section on end-of-life choices on the Australian Medical Association website. The AMA makes the point that end-of-life care is best managed around a conversation. The website states —

People do want to live with certainty about the end of theirs or their loved one's life. It has not been hard to arrive at the conclusion that we are the problem, we the health industry, we the clinicians. We are the death denying industry, we are the death denying profession and until we —

Health professionals —

stand up and lead the way on this subject, our society will continue to suffer.

I quote an article from *The West Australian* about Scott Blackwell, formerly of the AMA. It says —

Scott Blackwell was a former president of the AMA and a leader in palliative care in Western Australia. He said that his own personal experience of the death of his wife, Naomi, strengthened his view that end-of-life care is about a person, not their tumour marker score.

The best indicator to measure the success of that process is how well the family grieves after their relative has died.

Further in the article he says —

“In my conversations with families of residents, I stress that hospitals are where you go to get fixed, not where you go to get care,” he says.

“If there is nothing that can be fixed, the best care you can get is in the residential care facility or at home.”

The article continues —

Doctors can be too busy trying to treat or cure, when sometimes the most humane approach is to step back and have a different conversation ...

Dr Blackwell said —

“It's about minimising suffering and maximising life ... Alleviating suffering is the most important thing I can do, and I'm proud to say I work in a team that is really good at that.”

I held a forum in my electorate. I held only one; I wish I could have held more. I held it in Rossmoyne. It was in a smaller facility than I wanted, but it was the only one I could get with the amount of time I had to organise the event. It had the capacity to hold about 100 people. I sent out letters around the area of the hall inviting people to the forum. Within 24 hours of that letter hitting letterboxes we had a full house and we had to start taking extra names of those who wanted to come but who we could not fit in at that point. Eventually, when the forum was held, we had about 120 people in the venue. To a person, they thanked me for holding the forum. Three people out

of that 120 stood and spoke against voluntary assisted dying, but they did so respectfully and politely. They were vehemently opposed to it. My judgement of people in the room was that the vast majority were in favour and the keywords they kept saying to me when I spoke to them over a cup of tea after the forum were “choice” and “control”. I had some emails from people who could not attend, and I want to share them with the house. The first is from Ted McEvoy, which I got, I think, the day after we sent out invitations. Ted lives in Bull Creek. He said —

Greetings Sue,

Thank you for your invitation to attend forthcoming the VAD forum.

I would have enjoyed attending the forum but I will be out of the country.

I'll be in the process of ticking off one of items in my bucket list by travelling on the **TransMongolian Express**.

I'm sure you would be aware of other similar situations but this is my personal circumstance. I have/had two daughters both born after my service in Viet Nam 1967/68.

My elder daughter (Fiona) was born on 9th October 1969. Fiona's younger sister (Brianna) was born 31 January 1973.

Around 20 years ago, Fiona was diagnosed with Crohn's disease—she was urgently transported by the fantastic RFDS to Fremantle Hospital for emergency surgery.

As a consequence, she lost her bowel.

Five years ago she contracted breast cancer and was treated by the excellent Prof Arlene Chan.

Following a regime of aggressive chemotherapy, a double mastectomy and reconstruction, her cancer went into remission.

However, late last year, Fiona noticed a large lump in her abdomen. The cancer had spread into her vital organs.

She was admitted into Hollywood hospital in early January this year. The prognosis was terminal.

Fiona's parents, her close and extended family, her many friends witnessed her struggles to remain alive whilst suffering absolute agony and pain.

She passed away on January 2019—she was 49yo.

After being directly involved with the death of Fiona, I am absolutely convinced as to the proposed VAD legislation.

I've copied this email to my local MLA ... to ensure he is aware of my strong opinion.

This issue transcends petty politics—I would hope that all members of the WA Parliament will carefully examine their individual consciences and make a concerned decision.

Sue ... with this email, I give you the rights to use it as you see fit, although with my express approval to do so beforehand publication.

I confirmed to him that I would use it. I received two other emails. I will not name the people who wrote these two emails to me, because I do not have their specific permission, but I will read them. The first says —

Good afternoon Sue

I am a 67-year old resident of Murdoch, Western Australia.

Over the years, I have witnessed family and friends become seriously ill, incapacitated and distressed about their frailty, medical issues and quality of life. For the last six weeks of my grandmother's life in hospital, she kept repeating “I want to die” to every visitor. She was mentally alert but she had no hope of leaving hospital. It was awful to watch her decline. She had no control over her future.

If you are monitoring your electorate's support for the Euthanasia Bill, please add my name to that list. I believe the Bill is a humane option for seriously and terminally ill people with little quality of life and no options for improvement.

The last email I want to refer to states —

My Dad died earlier this year. It was one of the most grateful times I've had in my life, I was able to give my dad the death he wished for. I nursed him at home and he had his final moments surrounded by us. This was made possible due to; being a nurse, having an understanding workplace and colleagues, a understanding and very supportive husband and supportive family and friends. All very specific things that aren't available to everyone.

We had left the hospital the final time, after spending what had seemed like the last several years in and out of hospital, this was the final time. The nurses were crying, they all knew this was it and Dad was on his last journey. We had made a pact that we wouldn't be going back, we would deal with whatever came our way together and at home. For Dad a hospice was not an option. We were given a wonderful palliative care nurse who visited once a week, they were all amazing and this service is completely invaluable in our community.

While this journey was incredibly powerful and special, there were many moments that were scary and uncontrollable. Our last Christmas Day dad spent in agony, the palliative team came and did all they could to control his pain. We all agreed the year before we'd call our final Christmas as that was the last year we were all able to enjoy. Unfortunately the end of his life was marred by uncontrollable pain. There were incredibly special moments but also incredibly scary moments. One of the scariest and painful things was the unknown. What would be next, when is the next? We had been given several scenarios of his potential death and none seemed peaceful and some were completely petrifying. We all lived with this unknown in his final days, hanging over us all, he was scared and vulnerable. He was a proud man his entire life and wanted to remain this way. In his final days he shrunk away, there wasn't a quality of life, he seemed to have already slipped away. He wanted to die with dignity and I fought extremely hard to maintain this for him, but as explained earlier this isn't always accessible for everyone. Not everyone has a child who is a nurse, who has the ability to take time off, who can move into their parents home. Not everyone wants to nurse/care a person in these final stages, it may be too confronting, too much even or have financial commitments.

I don't know what may have happened for us had Voluntary Assisted Dying been legal at the time. But I do know that the options for people in the most vulnerable process of their life should be made available to them. That humans have the right to choose their own death with dignity and peace.

This story is incredibly personal and painful to me and my family. We don't often speak about it and I only share this story with you to encourage you all to support the Voluntary Assisted Dying Bill.

I want to end where I began. This bill is about the timing of the death of those who are already dying of a particular terminal illness. Western Australians want us to give effect to their voice. They want this legislation to pass. They expect us to examine it in detail but they want us to do it efficiently and in a timely way. I know we can do this and I hope we will.

**HON PETER COLLIER (North Metropolitan — Leader of the Opposition)** [4.13 pm]: All of us know that this is probably one of the most profoundly emotional issues that we will ever have to deal with. I have had to deal with it twice now in this chamber; once with a motion by Hon Robin Chapple back in 2010. Prior to that, it had been dealt with six times. This is the first time it has been by government-sponsored legislation. As I said, it is a highly emotional issue. Given that, the Liberal Party made the right decision to make it a conscience vote, the same as all parties in this chamber. Can I say hand on heart that I have not spoken to one member of the Liberal Party to access his or her views on this legislation. I have not tried to intimidate, cajole or influence any member of the Liberal Party with regard to this issue. We have not discussed this issue in our party room. I want to make that one thing perfectly clear. Every member of the Liberal Party who stands today will base their contributions and views upon their conscience.

As I have said, it is a very, very emotive issue. In anyone's language, two of the most profoundly emotional issues that any Parliament will have to deal with will be at the beginning of life and at the end of life. By design, in Australia over the last three months, we have dealt with the beginning of life—the conception; the abortion debate in New South Wales—and here in Western Australia we are dealing with the end of life, or euthanasia. The sanctity of life is paramount. Inevitably, those two issues are going to elicit an enormous amount of emotion. They deserve an enormous amount of scrutiny when we decide what is best for conception and what is best for death. We must scrutinise this legislation thoroughly and comprehensively. I make no apology for that. The sanctity of life is wonderful; it is paramount.

I will talk a little later about some personal influences with regard to where I stand on this legislation. I have pretty much been blessed with good health. Although I have seen a number of people around me not in such a situation and who in fact have suffered terminal illness and ultimately death, personally it has not impacted on me. I have come to a decision on where I will vote on this legislation based upon an enormous amount of research and an enormous amount of consultation and also how I feel personally about the sanctity of life.

Having said that, let us look very briefly at where we are at as a community in terms of dealing with the beginning of life and the end of life, and whether we give both elements due respect. Looking at the beginning of life in terms of the resources that we provide from conception to birth and then early childhood, the resources are legitimately phenomenal. Firstly, at the prenatal stage, public or private, there are state and federal contributions towards the pregnancy confirmation and check-up; the first trimester check; the ultrasound; monthly check-ups; prenatal and parenting classes; and full support at the hospital for high-risk pregnancies. In terms of maternity, public or private,

state and federal contributions: full support is provided during the birthing process in hospitals of choice—public fully funded/private partially funded via the Medicare gap cover—there is postnatal support in hospital for two to 10 days; breastfeeding support; and postnatal mental health support specifically aimed at postnatal depression. Child health, local governments, zero to five years: compulsory check-ups at regular intervals with a baby nurse; measured developmental support; ongoing breastfeeding support and ongoing mental health support. Immunisations, local governments, state and federal contributions: the schedule of immunisation starts at birth and goes through to adulthood; it is now compulsory, with no jab, no play. Federal financial support is tied to the immunisation schedule. Financial support, federal government, paid assistance: there is a raft of federal government assistance, including maternity allowance, paid parental leave, family tax benefits A and B, childcare assistance, parenting payments and so on. Support for parents includes family tax benefits, parental leave pay, dad and partner pay, additional childcare subsidy, parenting payments and so on.

The point I am making is that there is nothing more beautiful than the birth of a child and raising that child. We as a community give that child due respect. We provide all that we possibly can so that that child—he or she—can be the best that they can possibly be through nurturing. In some instances, of course, it does not work out that way because of community dynamics, but we as a community do all that we possibly can.

Of course, there are issues when it comes to the end of a person's life. The Royal Commission into Aged Care Quality and Safety has heard some extraordinarily disturbing revelations. The end of a person's life due to a terminal illness is very confronting for the individual and the friends and family of that individual. It must be extraordinarily confronting for a person to go into a doctor's surgery and be told that they have a terminal illness and limited time to live. We provide support mechanisms for that individual, but do we provide sufficient support mechanisms in all instances? Do we provide the same support services for an individual in Perth as we do in Melbourne, Sydney or Brisbane? Do we provide the same support services for an individual who lives in a remote Aboriginal community in the Kimberley? Do we provide equivalent support services for someone who lives in a mining town 200 miles east of Kalgoorlie—or in Meekatharra, Albany or Bunbury? We do not. Members do not have to take my word on this. The support services, in particular palliative care services, that we provide for individuals are sporadic at best in a lot of instances and non-existent at worst in a number of other instances. To suggest that an individual who has a terminal illness has the appropriate mindset to decide whether they will access the provisions of the voluntary assisted dying legislation and end their life is an issue we need to consider. We should not put the cart before the horse. At this stage, can we as a community put our hands on our heart and say, "Yes, we provide the support mechanisms for every individual who has a terminal illness"?

Members do not need to take my word for it. This Parliament has done an enormous amount in the area of palliative care. "My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices" is comprehensive. One chapter specifically deals with palliative care. Hon Nick Goiran's minority report, "The Safe Approach to End of Life Choices: License to Care Not Licence to Kill", also provides a considerable amount of information about palliative care. I will take a bit of time—not too long—to go through the particular recommendations in both the report and the minority report and what they have to say about palliative care. Chapter 3 of "My Life, My Choice" is appropriately titled "Palliative Care" and it states, in part —

It has long been held that palliative care should neither hasten nor postpone death—indeed, this premise can be found in the World Health Organisation's definition:

*Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:*

- *provides relief from pain and other distressing symptoms;*
- *affirms life and regards dying as a normal process;*
- *intends neither to hasten or postpone death;*
- *integrates the psychological and spiritual aspects of patient care;*
- *offers a support system to help patients live as actively as possible until death;*
- *offers a support system to help the family cope during the patient's illness and in their own bereavement;*
- *uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;*
- *will enhance quality of life, and may also positively influence the course of illness;*

- *is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.*

Palliative care is intended to assist in relieving symptoms and would usually commence once a patient has accepted that curative treatments are no longer appropriate. According to the University of Western Australia, palliative care is:

*[...] an approach to care that involves acceptance that the underlying condition is not responsive to curative treatment (or a decision has been made not to treat with curative intent.)*

That is a fairly accepted and appropriate definition of “palliative care”. The report is quite compelling about whether we provide palliative care across Western Australia. For example, on page 64 it refers to where people receive palliative care treatment, and states —

Consistent with access to medical care across Western Australia generally, how patients access palliative care will vary depending upon their socio-economic status and whether they are located in the regions or in the Perth metropolitan area.

That in itself is a problem; people who live in regional Western Australia may be less significant than someone who lives in the metropolitan area. The report goes on to say —

WA Health provided a list of the 28 services currently accredited to provide specialist palliative care:

It lists them, but I will not go through them all. It continues —

The models of care available at each of these facilities differ and it would not be correct to suggest the level of palliative care provided is equal across them all. For example, four of the WA Country Health Service regions only have access to consultative specialist palliative care. Without access to inpatient or community specialist palliative care patients do not have the same level of choice as patients in the other parts of the state.

I emphasise that this is in the “My Life, My Choice” report. Finding 9 states —

Access to inpatient specialist palliative care in Perth is limited.

Finding 10 states —

Apart from a small number of private beds at Glenngary Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs of Perth.

Recommendation 7 states —

The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

I understand that in recent times the government has committed to that in the northern suburbs, which is good and wonderful, but we still have a way to go before that facility is established and before we know whether it will be adequate. Finding 11 states —

Silver Chain is providing community palliative care to more patients than for which it is funded.

Recommendation 8 states —

The Minister for Health should ensure that community palliative care providers, such as Silver Chain, are adequately funded to provide for growing demand.

The report then refers to palliative care in the regions, and it is quite compelling. I am sure that most members would have read the report and learnt about the deficiencies in palliative care facilities in the regions of Western Australia. All I am saying is that, at the very least, we have to get to a point at which palliative care facilities in the regions of Western Australia are remotely adequate before we ever go down the path of saying, “This is perhaps your other option.” I hate to think that that will be the situation for some people who live in the regions, particularly those in the remote areas of the state. I will come back to that a little later.

I will briefly touch on the recommendations in Hon Nick Goiran’s minority report, because they pretty much mirror those in the majority report about the lack of palliative care facilities, particularly in the regions.

Recommendation 1 states —

The Minister for Health should consult with the Palliative Care Outcomes Collaboration (PCOC) and service providers to determine a data collection methodology that would set the lowest figures for unmanaged pain symptoms as the aspirational standard for every service provider.

Recommendation 2 states —

**Extract from *Hansard***

[COUNCIL — Tuesday, 15 October 2019]

p7533c-7550a

President; Hon Nick Goiran; Hon Sue Ellery; Hon Peter Collier

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The Minister for Health should consult with palliative care service providers to ascertain the current deficit in capacity preventing equitable provision of specialist palliative care across Western Australia.

Recommendation 3 states —

The Minister for Health should assess the recommendations made by Western Australia's peak body for palliative care and report to Parliament with a plan to:

- a) utilise co-design workshops;
- b) progress the Compassionate Communities model;
- c) introduce shared care models;
- d) increase the capacity of the Silver Chain Hospice Care Service model of care;
- e) build the capacity of existing outpatient clinics to facilitate Advance Care Planning; and
- f) increase the availability and flexibility of Telehealth.

Recommendation 5 states —

The Minister for Health should develop and roll out a community awareness program about specialist palliative care services.

This is another area that has been identified in the “WA End-of-Life and Palliative Care Strategy 2018–2028” and by the Ministerial Expert Panel on Voluntary Assisted Dying in its findings. There is a real lack of understanding about the palliative care facilities that are provided in Western Australia. Not only that, there is an enormous disparity in the palliative care facilities that are provided across the length and breadth of Western Australia.

I turn to the final report of the Ministerial Expert Panel on Voluntary Assisted Dying, which reinforces exactly what was stated in the report.

Debate interrupted, pursuant to standing orders.

[Continued on page 7560.]