

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 17 October.

HON COLIN HOLT (South West) [2.11 pm]: I will not take up too much of the house's time, but I will make a couple more points. Last week when I contributed to the second reading debate on the Voluntary Assisted Dying Bill, I used the journey of my father, who died from bowel cancer, and I want to make a couple of extra points about that journey. I left it when I was talking about the need for a specialist opinion, as required by the bill. All through dad's journey, from going through chemotherapy, radiation and bowel operations to the point that it was decided that it was time for him to go home and be made comfortable, there was never a question about his capacity to make decisions—that is, to either consent to or refuse treatment. He saw a range of GPs and specialists who never sent him anywhere for further assessment of his capacity to make a decision. They would have ascertained that he had that decision-making ability, and in my mind that is exactly how it should have been, because he was very clear in his thinking the whole way through. I certainly never questioned his ability to make a clear decision about consent to or refusal of treatment. I will explore this in a bit more detail, because there are a number of other examples in which medical professionals make assumptions about people's ability to make decisions or whether they have the capacity to make decisions.

One of those is the implementation or development of an advance healthcare directive. Of course, members will know that an advance healthcare directive is a signed document in which a person outlines their future medical treatment if, at a point in time, they cannot make a decision or give an indication about the type of medical treatment they want in the future. The Joint Select Committee on End of Life Choices went into them in some detail and recommended that there be further investigation on the uptake and promotion of advance healthcare directives, and the government, through the Attorney General's department, established a group to look into that. I want to explore this in more detail because when people make an advance healthcare directive, they can make a number of different care directives. One example I have come across states, "If I have a terminal illness, I do not want any life-sustaining treatment. Please just keep me comfortable and pain-free until I die." People can write in their advance healthcare directive now. Another one that is often used is, "If my heart or my breathing stops, then I do not want to be resuscitated." Members may be familiar with do-not-resuscitate orders. When people make advance healthcare directives, what is the assumption about their capacity? For all intents and purposes, advance healthcare directives contain very big life and death decisions.

I turn to a template I got off the Department of Health's website. One of the template questions is —

1. **Treatment decision**

In the following circumstances:

People have to fill in the blank lines with the situation —

I consent/refuse consent (cross out or initial one of these)

to the following treatment:

The examples I have given would fit into this template. At the beginning of the template, the notes state —

- To make an advance health directive, you must be 18 years of age or older and have full legal capacity.

That is the way that doctors assess whether a person has the capacity to make decisions. That is what people need to fill out an advance healthcare directive. The footnote says that it pertains to section 110P of the Guardianship and Administration Act 1990, which states —

Making advance health directive

A person who has reached 18 years of age and has full legal capacity may make an advance health directive containing treatment decisions in respect of the person's future treatment.

That is pretty clear, and reiterates what is in the template. In section 4, "Principles stated", full capacity is articulated. It states —

- (3) Every person shall be presumed to be capable of —
 - (a) looking after his own health and safety;
 - (b) making reasonable judgments in respect of matters relating to his person;
 - (c) managing his own affairs; and
 - (d) making reasonable judgments in respect of matters relating to his estate,

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until the contrary is proved to the satisfaction of the State Administrative Tribunal.

There is the presumption that people can make decisions until someone says, “Hang on a minute. We think there are some problems”, and that person needs to prove that that is the case. Advance healthcare directives presume that people have the capacity to make their own decisions. There are similar provisions in the bill, although they are not directly lifted from that. Clause 6 states —

- (2) For the purposes of this Act, a patient has *decision-making capacity* in relation to voluntary assisted dying if the patient has the capacity to —
 - (a) understand any information or advice about a voluntary assisted dying decision that is required under this Act to be provided to the patient; and
 - (b) understand the matters involved in a voluntary assisted dying decision; and
 - (c) understand the effect of a voluntary assisted dying decision; and
 - (d) weigh up the factors referred to in paragraphs (a), (b) and (c) for the purposes of making a voluntary assisted dying decision; and
 - (e) communicate a voluntary assisted dying decision in some way.
- (3) For the purposes of this Act, a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

That suggests that there is consistency with what we expect from advance healthcare directives and people making decisions about their life and how they will be treated, and how this will apply under this legislation. In my opinion, that is the right way that it should be done. If there are any doubts by the consulting or coordinating practitioners, there is proposed section 25, “Referral for determination”. I want to paint the picture again. We assume that people who will sign up to or qualify for voluntary assisted dying, after meeting all other qualifications, will have capacity—that is, presumed capacity. But if any doubt exists, proposed section 25 provides —

- (1) Subsection (2) applies if the coordinating practitioner is unable to determine whether —
 - (a) the patient has a disease, illness or medical condition that meets the requirements of section 15(1)(c); or
 - (b) the patient has decision-making capacity in relation to voluntary assisted dying as required by section 15(1)(d).
- (2) The coordinating practitioner must refer the patient to a registered health practitioner who has appropriate skills and training to make a determination in relation to the matter.

There will be a presumption that a person will have capacity—my dad’s case was a perfect example of that because he had capacity—but if there is any doubt, the bill provides that they must be referred to the right practitioner or specialist for assessment.

I will now take the argument one step further. Think about someone who has been rushed to hospital in a coma. They cannot communicate and, obviously, they cannot assent to or refuse medical treatment. What will the medical team do in that situation? In an emergency, they act immediately, because their first action is to save life. But what will happen when someone in a coma, who cannot give permission for what is about to happen to them, is taken to hospital and they do not require urgent treatment? What will the medical team do? Firstly, the medical team must ask whether the patient has an advance healthcare directive. If they do, the medical team must do what it says in the advance healthcare directive. Remember, the advance healthcare directive was made way back when there was a presumption of capacity. If there is no advance healthcare directive or it does not have the specifics of “If I get this, I want this treatment”, the medical team must go to something known as the hierarchy of decision-makers. That means that they basically have to ask the patient’s family members to make a decision. I downloaded from the website of the Office of the Public Advocate a page titled “Hierarchy of treatment decision-makers”, which notes —

Where an AHD does not exist or does not cover the treatment decision required, the health professional must obtain a decision for non-urgent treatment from the ... person in the hierarchy who is 18 years of age or older, has full legal capacity and is willing ... to make a decision.

The first person in the hierarchy is an enduring guardian with authority. If there is no enduring guardian with authority, next in line is the guardian with authority. If there is no guardian with authority, the next person is the spouse or de facto partner. Next on the list is an adult son or daughter, then a parent and then a sibling. If none of those people are found or are unwilling to make a decision, the next person in the hierarchy is the primary unpaid caregiver. If they cannot be found, the next one is other person with close personal relationship. That is the hierarchy that applies to an incredibly important decision on someone’s behalf, even for a wife, brother, sister or child.

Within the hierarchy of decision-making, there is still the presumption of full legal capacity. That will only come into question when a medical team asks, “Does this person have the mental capacity to make a decision on behalf of someone else?” If they do not have capacity, the medical team will need to go to another decision-maker. Again, it is making a presumption about decision-making capacity in a life or death situation. I think that that is an important consideration. I know that there has been some talk about the automatic mandatory referral of some patients under the voluntary assisted dying legislation to a specialist psychologist or psychiatrist to ascertain whether they have the capacity to make a decision. That would be a very unusual step, because we do not do that in other life and death situations.

To round off dad’s story, I would say that dad had exceptional palliative care. When I asked mum whether she thought he was in pain towards the end, she said, and I would go along with her, that he was probably one of the very lucky ones. The MS Contin did the trick; any time he wanted more, mum would give him more. I can absolutely say that he was very peaceful at the end of his days and that he was one of the lucky ones who had exceptional palliative care at home. He was able to die at home with mum looking after him in his last few days, with some visits from Silver Chain. That model worked really well.

I have nearly come to the end of my contribution, but I want to finish on another point. I took my twin boys, who were 10 years old at the time, to see dad the night before he died. I talked to him and mum, and while I was chatting, each of the twins held one of his hands. That was the last time any of our extended family spoke to dad. We left and mum was there when he died the next morning. I can say that I am probably lucky because I got to say goodbye to dad. I did not know that it would be the last time I would see him, but I can say I am the luckiest of his six kids, 20 grandkids and his 20-odd great-grandkids because I, and my twin boys, were actually there to say that goodbye. This is another important point: I am sure that my siblings and extended family would have liked the opportunity of at least saying goodbye before he was gone. That is one point around the outcome of voluntary assisted dying—if you are in that situation, and you are dying, you can have your family around you and you can choose the moment you say goodbye to your family. There is no potluck about what other treatments occur. Dad was sedated and went into a deep sleep when the dose of morphine was upped, and no-one had any idea how long he would last. When we think about people in those last hours, last moments, of their lives, I am sure that they would like to be surrounded by the people who are the most dearest to them. That is another reason why I support this bill and this policy.

Palliative care specialists say that if the pain gets too great for anyone—we know not everyone is as lucky as dad—they up the medication to put them into a palliative sedation or terminal sedation or, as Dr Anil Tandon likes to refer to it, a “deep sedation”, which is basically putting them into a deep sleep so they do not suffer any pain. Again that is a debatable point, because the Joint Select Committee on End of Life Choices heard plenty of evidence that people in deep sedation can have physical pain, although I would question how people know that. I think it would be based on the observation of those closest to them who sit there and witness it and would give their ongoing evidence to say, “Yes, we believe our loved one was in pain.”

I looked for a definition of “palliative sedation”. CareSearch, a palliative care knowledge network, defined it as —

Palliative sedation is regarded as the use of sedation until death in the terminal phase, for symptoms that are resistant to other treatment measures.

They know the outcome: it is about putting someone to sleep until they die. In fact, there have been some arguments that we do not need voluntary assisted dying laws because we can use terminal and palliative sedation. So why do we need these laws? There is a number of reasons, and one is deciding the time when you say goodbye to your loved ones. Another is that palliative sedation is unregulated—it happens in consultation between a parent and a consulting doctor and their GP. There is not a lot of regulation around it. As I said, we cannot predict the outcome or when exactly that outcome will occur.

To finish off, I will come back to the way the laws are at present in Western Australia. A person diagnosed with a terminal illness who is coming to the end of their days has a number of ways of controlling that endpoint. One of these is refusal of food and water. A person can probably go for about three weeks without food, but lack of fluids can result in death within three or four days. To me, that seems like a very desperate measure for a terminally ill person. We have evidence that this occurs in Western Australia. We have heard other evidence, and other members speaking about taking control of their own lives and committing suicide way before they need to, while they are still capable of taking those things into their own hands. Again, I think that is a desperate measure, and a tragedy. They go way before they need to because they are worried about the endpoint. Often, they do it in isolation, away from their own friends and family, because they do not want to implicate their friends in that.

I think Hon Jacqui Boydell, in her contribution, said that even if someone chooses the voluntary assisted dying pathway, it does not mean that palliative care provision stops for that person. It is the same for someone who refuses food and drink. I found a fact sheet released by an organisation called End of Life Direction for Aged Care,

which is a national specialist palliative care and advance health care planning advisory service. The fact sheet is titled “Medication for pain and symptom relief for people with a life-limiting illness”. It states, in part —

Pain relief for a person who refuses food and water

Sometimes, a person who is close to death may refuse food and water. This is legal if the person has capacity to make this decision. **Everyone has the legal right to refuse food and water, even if this results in their death.**

When a **person decides to stop eating and drinking, palliative medication can be given** to reduce any pain or suffering they experience from this.

Even though people make desperate decisions, they should continue to receive palliative care to make their life and their passage more comfortable.

One of the other statistics that I found quite interesting was that, in Oregon, 40 per cent of people who go through the process and actually receive the medication do not take it. We have to ask why that is so. I am sure that some of them go through the process to make sure that it is there if they ever need it. That 40 per cent may pass by other means and do not need to take the medication, but the fact that they have it gives a great deal of comfort, and they know that it is there if they need it, and that is an important point.

I believe that we can do better for those who are terminally ill and suffering at the end of their life. I think we can do better as a society and as a Parliament for Western Australians. My support for this bill is not for those who have already passed, although their stories and their evidence have certainly informed my view of this legislation. My support for this bill is for those who will face their final days in pain and suffering in the future. Those are the people who are asking for another option—the choice of a peaceful passing at the time of their choosing surrounded by their love ones. That is what drives me to support this legislation, and I urge members to put patients at the forefront when voting on this bill and any potential amendments. I thank all members, all the members and staff of the Joint Select Committee on End of Life Choices, who did all that work two years ago, the ministerial expert panel, and all the people who wrote to me, from all sides of the debate from all over Western Australia, not just the South West Region, to express their views and tell their personal stories, which informed the debate very well, and helped to focus what I thought this bill was about.

HON MATTHEW SWINBOURN (East Metropolitan) [2.35 pm]: I rise to make my contribution to the second reading debate on the Voluntary Assisted Dying Bill 2019. From the outset, I want to indicate my support for the bill. In my speech I will give an idea of how I came to that opinion. The nature of my speech today will be to put on the public record my reasons for supporting the bill. I feel it is a duty for all of us who are able to do that. My contribution is not meant to persuade or dissuade anybody from their position. I have come to my view based on my own reasons.

Echoing the final comments of Hon Colin Holt, I would like to make some acknowledgements to begin with. The first acknowledgement is of the Joint Select Committee on End of Life Choices. That includes all its members and the committee staff, who work very hard on all our committees and often do most of the serious leg work. The committee members are very well served by them. I also acknowledge those people who have taken the time to write to me, both through emails and in the old-fashioned way; I think it is the most correspondence I have received through the postbox for a long time. People have written to me earnestly expressing their views. Of course, I have faced the same sort of arguments for and against, the most common one being, “This is my view, and I’m your constituent, so you should do what I tell you to do.” That is plainly impossible. I cannot keep all the 400 000-plus constituents of the East Metropolitan Region happy, as much as I might try. We have had an exceptionally large amount of correspondence—well over 1 000 now—so I would also like to thank my staff, who have had the laborious task of dealing with all that correspondence. Reading the stories and points of view that have come through that correspondence has had an impact on them as much as on me, so I especially want to note my staff. The members of the ministerial expert panel have dedicated themselves with great care and application to the task given to them by the government. I cannot imagine that the process has been easy for them, and, for some of the medical people on that panel, within their own professions. I acknowledge them as well.

Like all members here, I have sought to engage with the community on this issue as much as I can. I met with constituents in my office, but I have also met constituents in and around my electorate. If I go to an event, constituents feel compelled to express their views and ask me how I intend to vote, and at times ask me to explain why I am voting that way. In all instances, that has been done respectfully even when a person has a different point of view. I have met with people who are against voluntary assisted dying, and, again, those people have conducted themselves in a respectful manner, and I have shared my views with them, and they have taken those on board. Dr Tony Buti, the member for Armadale, and I also hosted a public debate in the Kelmscott Hall, which was attended by over 100 people. The debate was between Dr Michael Gannon, former Australian Medical Association president, and Dr Scott Blackwell, also a former Australian Medical Association president and a member of the

ministerial expert panel. I thank both Dr Gannon and Dr Blackwell, and my friend Dr Tony Buti for putting that on, and providing an opportunity for this issue to be ventilated in the community. The debate was not so much about presenting an argument in favour of voluntary assisted dying. It was genuinely a debate between two proponents who had different views.

I also had the opportunity to visit the palliative care unit at Kalamunda Hospital with Hon Nick Goiran. I thank Hon Nick Goiran for organising that visit and bringing me with him. I thank the staff at Kalamunda Hospital for facilitating that visit, particularly Dr Andy Hart. That visit gave us an appreciation of what is happening in the field of palliative care within my electorate. The staff at Kalamunda Hospital are doing good work. It is a nice place. It has further capacity. They have grand plans for that, and I look forward to seeing those increases in palliative care funding work their way through the system. If members have not had the chance to go to Kalamunda Hospital, it is a nice spot. It sits alongside the forest. If I were looking for a place in which to spend my last few days, that is the kind of place that would appeal to me. We are not all sand and surf people. Some of us are hills and trees people. We want to provide variety in that as well.

I have also attended the numerous briefings that have been made available to all members. I thank those people who have taken the time to brief us. The most instructive of those briefings were when people came not to advance a particular point of view, but to provide information. From the point of view of the task that we have, I have found that most helpful and instructive.

It was not possible to read every piece of correspondence that I received and I will not pretend that I have, but I tried to read as much as I could. The stories that were presented to me were certainly very compelling, and people eloquently put their arguments for and against.

I would like to talk about what does and does not inform my position on voluntary assisted dying, and the general issue of euthanasia. Of course, I am instructed by my values. One of those values is the idea of personal autonomy, and the person's right to have their autonomy respected. Having gone through a number of highly complex medical scenarios, the idea that the patient comes first is particularly important to me. When people start to make decisions for us, the outcomes tend to not be as good as they should be. For me, personal autonomy in any environment is particularly important. That extends to children. Children should also very much be at the centre of any medical model. I have spent many nights at Princess Margaret Hospital for Children and have spoken to nurses who have been in the system for a very long time. They often describe the good old days, in one sense, when parents were permitted to visit their children at the hospital only on a Wednesday and Sunday afternoon. There was no sense that the parents and the family should be involved in the needs of the child who was sick and in the hospital. I do not think any of us could contemplate the thought that we would be given such restricted access to our own children in a medical environment. The focus at the new Perth Children's Hospital is on family-centred care. The patient is at the heart of that. That is opposed to the paternalistic idea that existed in the past and that was imposed on patients—that doctor and matron know best. Patients did not get a great say in their treatment course. They were not informed of their options and what their treatment path would be. It would be fair to say that the medical profession as a whole—doctors, nurses and allied health professionals—has moved a long way past that. There is now an overwhelming recognition that patients and their wishes must come first. For me, in the voluntary assisted dying debate, that does not change. The person who has the terminal illness or neurodegenerative disease must come first and their wishes must come first. Nothing should be able to overcome that in these circumstances.

As Hon Aaron Stonehouse said in his contribution, it is a matter of liberty. I listened very carefully to his contribution and I appreciated it very much. A couple of members have made contributions that I particularly appreciated. That includes Hon Tjorn Sibma, who is out of the chamber on urgent parliamentary business. The way in which he characterised voluntary assisted dying was very helpful for me. Unfortunately, I missed the substance of Hon Jim Chown's contribution, but parts of it had some influence on me as well.

I am not a religious person. I have never been a religious person. Therefore, religion does not inform my position. I want to be very clear about that. It is important that people understand that that is not one of the biases that I bring to this debate. I have my own biases, of course, but I am not a religious person. Having said that, I accept that some people have those particular points of view. I respect their entitlement to be informed by their religious beliefs. I would hardly be one to respect personal autonomy if I were then to impose on others that they could not hold their own particular beliefs about certain things.

I also hold very dear the belief that people who have capacity are entitled to make their own decisions. That is particularly the case for young people, the frail, the elderly and people with disability. Having been involved in the inquiry into elder abuse, it was put front and centre of us that we should never lose sight of the fact that the elderly have agency—they have the right to make their own decisions, good or bad. That is an entitlement that we cannot take away. That comes back to the sense of paternalism that sometimes permeates our culture, with the idea that, "I know what is best for you, because you do not have all your faculties." If people have their faculties, regardless of their other attributes, they should be able to make decisions for themselves. That includes people

with disability. I especially detest paternalism and the “I know what is best for you” mentality. That is not to be confused with the idea that those who are experts in their field and who are trying to help others prevent harm to themselves, through education programs or through the extension of safety measures into our society, are necessarily being paternalistic in their approaches. I would not want people to think that I was casting any kind of aspersion on their attempts to improve the health and wellbeing of people in our society.

I have always generally supported the concept of euthanasia, and that it be voluntary. I am not really sure where that came from. Maybe it was because I was a middle child and hated being told what to do by everybody else. I am not sure whether that was the starting point or the finishing point, but perhaps that is where my sense of independence has come from. The idea that somebody could tell me that I could not take a course of action that I thought was appropriate for me rankles. That is one of the bases for the values that inform me.

I come now to the two core reasons why I support the bill. The first is my brother, Kerry. Kerry Evans was born five years after me. We are both Aries. I do not necessarily believe in astrological star signs, but we used to butt heads a lot, so that is probably where that analogy comes from, because he was five years younger than me. Kerry was a very active, healthy and athletic person. He had a very wicked sense of humour. He got under my skin many, many times. I speak about Kerry in the past tense, because he died three years ago of cancer. He was only 36 when he passed away. His cancer journey started in about 2008, when my youngest son, Darcy, was born. Kerry had had some strange symptoms for a long time. He had become quite hyperactive. He would wake up in the middle of the night and do odd things like gardening. He had indigestion. He had a number of different kinds of symptoms. He kept seeing his GP to find out what was going on, and the GP kept diagnosing things like anxiety or indigestion. His regular GP went on holidays, and he saw another GP in the same clinic. That GP went through his symptoms and immediately sent him to Fremantle Hospital for scans. They then discovered that a tumorous mass was growing on his kidneys. It was not small; it was the size of a cricket ball. There were other tumours in his body as well. These were a special kind of tumour called paraganglioma tumours. They emit what is in effect a kind of adrenaline around the body, which causes the person’s blood pressure to go up and the heart to race, hence his activities. The adrenal levels in the body are astronomical. The neuroendocrine effect of these tumours are so powerful that if someone is in surgery and there is a push from these hormones, it can take them out of anaesthetic. He was in hospital for a couple of days. When they were preparing him, they had to lower his blood pressure and get control of the hormones in his body. Once they had done that, they did surgery and removed his kidney and took out some additional tumours that I think were in his lungs. It was 2009 by this stage. As I say, Kerry was a very athletic, healthy person. I was always the overweight one and he was always the one giving me a hard time about it. It was therefore very strange to see this younger brother in the intensive care unit at Fremantle Hospital. I do not think the image of seeing him so helpless and in a different state will ever leave me.

Unfortunately, not a lot is known about these kinds of tumours. They are genetically based and do not come from any outside causes. There is a mutation in the SDHB gene, so that people who have that mutation have the propensity to grow these tumours. Kerry’s tumour had metastasised so he underwent a series of radiation and chemotherapy procedures over the next several years. There were times when we thought he was going to be cured. He would go into remission. However, I do not think I will ever forget the day—I was working at the Construction, Forestry, Mining and Energy Union—that he called me to tell me that the tumours had gone into his bones. It is a bad thing once they go into the bones; it is painful and difficult. From that point forward it got into his spine as well. It was not anywhere they could do surgery on. If we have tumours in our spine we do not have many options available.

There is no question that Kerry loved life; he loved living. His partner, Nicola, and he married when he was in a sort of remission stage. She was the love of his life. She brought such joy to him and he had a happy life. He lived happily. However, the disease progressed. He got more and more frail and weak. He was staying with us for a little while when he was using a wheelchair and walker. I remember him being in the shower for a long time and I wondered why he was in there for so long. When I went in there, I found that he had collapsed on the floor. He could not hold himself up because he did not have the energy to yell out. I had to pick him up off the floor—my adult brother, naked in that situation, completely vulnerable—and help him in that situation. He did not need that to happen. But Kerry kept going on and on. His disease progressed. He ended up in a wheelchair. He could not walk. Finally, in his last days, he ended up back in Fiona Stanley Hospital. He kept his sense of humour the whole time, but I remember the last few days. Others here have been through that bedside vigil-type thing. I do not know that I ever believed he was going to die. I probably did not. I always thought he might get a little bit better and would come back. But the disease kept progressing and we were there when he passed away. He was being sedated with morphine. He would grumble, groan and carry on and the nurse would be called in and would give him another dose, and it would go.

I guess I never wanted to talk about death with Kerry, so we never sat down and talked about it. I do not know what his views were about voluntary assisted dying. However, I would like to think that if he had decided about the time that he wanted to go, I would have been in a position to respect that and to go through that process with him as the young man that he was. He went quietly away. I do not know how quietly it was. I do not know what

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was going through his mind as he was being sedated with opioids. We do not know what goes through a dying person's brain when they are sedated. We presume it is some sort of happy dream, but we do not know how they go. He hallucinated during those periods as well. We look at that situation and say, "How would I be there?" I am not sure I would like to have been in the way he was. I spoke about Kerry with his wife, Nicola, and his circumstances. She said they spoke about voluntary dying, not perhaps in the context of this Voluntary Assisted Dying Bill. It was 2016, so it is not as though it was on the cards in that particular way. I do not think that at any point of Kerry's life he would have given up on living, but I would have liked him to choose the terms in which he went out. He was fortunate in the sense that his family was around him for his death. We were there and the children were there. They got to say goodbye in their way, but it obviously leaves an impact.

The underlying genetic condition that cost Kerry his life is a family condition. We did not know the family had a genetic mutation of this kind and following Kerry's diagnosis, he encouraged the rest of us to get tested by the Genetic Services of WA. However, we did not really take it seriously enough. In 2015, my middle son, Mitchell, developed the same tumour. He was 10 at that time and he is one of the youngest people known to develop a paraganglioma tumour. He started having symptoms around the Christmas before that. Some strange things happened. He had an enlarged nipple. We did not know why it was. We took him to the GP who said, "Oh, it might be early puberty." We went with that. We went overseas to Singapore for our first family trip. Immediately we got back, he became very unwell. He was vomiting and not holding food down and he became weakened. We kept going back to the doctors. Glenda, my wife, kept taking him to the emergency department to get a diagnosis. She knew there was a family condition in the background. She kept saying to the doctors, "Look for this and look for this." They did not look for it and when they did look for it, they did not tell us about it so she finally took Mitchell to the emergency department and was not going to leave until they gave her an answer. They looked at the blood work that had been done and they saw elevated hormones in his blood. It was a hard day, of course, to find that out. Scans were done and a second tumour was found. One tumour was attached to his venae cava, the descending blood vessel from the heart. Another one was in his stomach. The doctors could not tell where it was. Our scanning technology is very good but it is not perfect. In that circumstance, they were throwing up a range of possibilities, so the second tumour was a bit of a mystery. He went into hospital and was given the drugs to bring down his blood pressure and make sure he did not come out of the anaesthetic when he was cut open. The surgeons then did the surgery while we waited for some very, very long hours. The doctors came out in the only way I suppose doctors and surgeons can do. They were quite excited. They had got the first tumour and then they got the second one. It was a gastrointestinal stromal tumour, which are exceptionally rare in children. When I say rare, there had never been a recorded case known in Western Australia. I am not sure that one has ever been found in the rest of Australia. I hope there is never another one. The surgeons had to take part of Mitchell's stomach away. They got what they thought were safe margins of that tumour. It has been discovered that those types of tumours do not respond to radiation or chemotherapy, so he does not receive those kinds of treatments; he can just have surgery.

Mitchell's tumour was removed and we went through a very long period of him recovering. To achieve what they needed to the surgeons had to cut his little body open and go right in, so we had that sort of stress. He has been up and down with different surgeries. A couple of years later, we had the news that the tumour had metastasised and gone into his liver. That is where the tumours are now. There are several tumours there. His treatment options are all experimental. There is no known cure for his cancer. We have had the discussions with oncologists about the choices we make, the impact of the drugs he is on and where he might end up with that sort of stuff. He is now participating in a drug trial, run by a drug company, out of the children's hospital in Queensland. We are very fortunate to have that opportunity. That drug seems to have stopped the growth of new tumours and slowed down the growth of the existing ones, so we are fortunate there, but we also discovered that the tumours have now moved into his lungs as well. What happens in this situation—which I would not want anyone to ever have to go through—is that the disease just keeps progressing. When we think that we are winning the fight, we are not—we are just doing what we can.

Mitchell is the bravest and most stoic child I have ever met. I have not met every child in the world—I am sure there might be another one who is—but people just do not understand how brave that little boy is. He never complains. He has never once said, "Woe is me" or "Why can't it be somebody else?" He just battles on and continues. That changed earlier this year when he was taking a drug that really knocked him around. He could not walk anymore and he had sores on his hands and feet. He had lost his body condition and was in a wheelchair. He had to crawl around the house because he could not walk. He could not eat, and he was talking about having had enough. We had to take him off the drug. It was the drug that was doing that to him—the supposed cure—not the disease. We took him off the drug and he improved on a new drug. Fortunately, he is doing very well. The new drug does not have the side effects that the other drug had, and we are hoping we can get to a point where we can start to consider surgery to remove the existing tumours and buy him more time. Hopefully we will get to the stage where the medical fraternity and the scientific community understands his kind of disease enough to develop a cure. We hope we get to that point; we desperately, desperately hope that we do.

Mitchell will be 15 years of age in January. He will not be eligible for these laws at 15; he will not be eligible at 16 or 17, but he will be eligible at 18. His journey in life is not one in which he suddenly has a terminal illness and flippantly decides that he has had enough. If he gets to adulthood and can make a decision, his journey will have had so much suffering, so much pain, so much perseverance and so many other things that I could not, as his father, in all honesty deny him the right to choose to go on his own terms when he is ready to go. That is if he gets to that point, and I really hope that he never gets there. But how could I, as his parent, deny him that—to be here today, to vote against this bill? If he lies on his bed and says to me, “Dad, I cannot go on; I have had my time and I’m ready to go”, and I say to him, “Son, I’m sorry; I had the chance, but I let it go, and you’ll just have to wait it out and go when nature takes its course”, I could not do that. I just could not; I am sorry. Other people might be able to, and I am not suggesting that they are lesser people because of that, but for me, this is the compelling reason. When I see him every morning, there is not a moment when I do not think about how truly sick he really is and how I enjoy every cuddle he gives. Mitchell gives the best cuddles, if you ever get the chance. He is not like his older brother, Harrison, who would not touch me with a bargepole! Mitchell has never lost the sense of wanting to be in physical contact with his parents, so he gives the best cuddles. He does not say much, he does not talk much, but when he does have something to say he lets it out. Apparently yesterday he saved a raven in his classroom, so that was a good story to hear about!

As I say, I cannot deny him. I might be a coward because of that, but as a parent you just do not want to put yourself in the position of denying your child the opportunity to be released from pain. I think I speak for many parents who have children with cancer. There is not a day that you do not fight for their life, that you want them to live and that they want to live, but it takes them all. Kids go every year. I am not encouraging members to make these laws available to children; that is not what I am talking about. But some of them make it into adulthood, and they have had their journey and it is time, in my view, to let them make a decision on the one thing that they have very little control over, to give them some control back again. With those words, I commend the bill to the house.

HON RICK MAZZA (Agricultural) [3.04 pm]: Hearing stories like the one that was just expressed by Hon Matthew Swinbourn is the very reason why a decision on this bill is so difficult. I must confess that I have lost many hours’ sleep struggling and wrestling with the issue that is before us. Some of the lead-up to the bill being read in to this place and the debate commencing has been somewhat disappointing. There have been accusations that the Legislative Council was going to run interference on this bill. We are only at the beginning of day four of the second reading debate and there are only a handful of speakers left after me, so I think we have made double-quick time in moving forward on this bill. Having watched much of the debate on the monitor over the last week, I can say that it has been a very respectful debate, and I respect both sides of the argument.

The bill before us, the Voluntary Assisted Dying Bill 2019, proposes a process through which a person may access euthanasia, from requesting access to euthanasia to prescription dispensing, administration and disposal of the lethal substance that will end the person’s life. This bill will allow a medical practitioner to either terminate a person’s life, with the person’s permission, or assist a person to terminate their own life. The bill has been promoted to the community based on the premise that it will eliminate suffering at end of life, bearing in mind that all deaths are different. Some people are very fortunate in that they will nod off to sleep in their late dotage and never wake up; others are not so fortunate, and that is part of the cycle of life. We do what we can to minimise that suffering.

No reasonable person ever wants to see anyone suffer, and polling around this issue can easily have a very populist result, with a few targeted questions. I appreciate and respect the arguments that have been put forward by those who have proposed this legislation, and I think the government and advocates for the legislation have good intentions. But I seriously think there are some very concerning issues that could arise as time goes by. There are alternative ways of reducing end-of-life suffering, and they are what we are currently using in the form of palliative care. The Joint Select Committee on End of Life Choices released the “My Life, My Choice” report in August 2018. It revealed that we have inadequate and substandard palliative care systems, especially in rural and remote areas of the state. Palliative care is about improving the quality of life of those facing life-limiting illnesses, through the medical treatment of symptoms that may be physical, emotional, spiritual or social.

According to the report, specialist palliative care is provided across 28 government and non-government services through inpatient community and consultancy models in WA. Unfortunately, the models of care can vary, and the level of palliative care is not equal. For example, four of the WA Country Health Service regions have access only 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 other parts of the state. Finding 16 of the report found that access to hands-on specialist palliative care was limited for metropolitan and non-metropolitan patients. Finding 17 found that Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population. Finding 18 found that there is a gap in care for people who are seriously unwell but not close enough to death for admitted inpatient hospice care. Finding 19 found that there is limited access to palliative care medical specialists in regional WA, and finding 20 found that there is limited medical oversight coordination or governance of medical palliative care services in the WA Country Health Service.

According to the Western Australian Palliative Medicine Specialist Group, palliative care in regional Western Australia is as follows. The Kimberley has six specialist visits per year with each visit lasting one week. The Pilbara has one specialist visit per year. The midwest has 10 one-day visits. Geraldton has each visit for one day; two in Carnarvon. The wheatbelt has 12 visits per year, with three each to Northam, Narrogin, Merredin and Moora. The goldfields gets 12, with four in Esperance. In the south west, there are two resident specialists in Bunbury, but no adequate care in surrounding towns. In the great southern there is one resident physician in Albany, with two visits to Mt Barker, Katanning and Denmark. Looking at that list, palliative care in remote WA is nearly non-existent. I have expressed before my family's experiences with palliative care services, or lack thereof, in regional Western Australia and the fact that family and friends often take on many of those roles.

An article published in WAtoday on 28 August this year entitled "West Australians should not ponder euthanasia due to lack of care: End of life specialists" states there are only 15 full-time palliative care specialist in WA, with most senior end-of-life care specialists worried that the state's most vulnerable people might consider euthanasia because of an alarming lack of resources available in palliative care, especially in the regions.

Recommendation 13 of the "My Life, My Choice" report called for the Minister for Health to ensure regional palliative care be adequately funded to meet demand. I would be very distressed to find that people may elect to access voluntary assisted dying as an alternative to palliative care simply because the services are not available to them. I know the government has put some investment into palliative care, which I am sure many people will be very grateful for. A state government media release of 9 May titled "Palliative care package to support sickest Western Australians" reported —

The 2019–20 State Budget includes a \$41 million investment for extra support and enhanced community-based palliative care services across the State. This package brings the total investment by the State Government for palliative care services over the next four years to \$206.2 million.

Coincidentally, five days before the Voluntary Assisted Dying Bill 2019 was to be debated in this house, the government also issued another media statement on 10 October titled "Massive boost for palliative care services across Western Australia" stating that it was putting further money into palliative care. This time it is \$17.8 million on top of the extra funding delivered in the 2019–20 budget. That consists of \$9 million towards 10 inpatient palliative care beds in north metropolitan suburbs, \$6.3 million for the expansion of community-based services across metropolitan and regional WA to better meet demand, and \$2.5 million for enhancing rural and regional palliative care services by improving governance. The investment over those four years will be as follows. There will be \$3.6 million to the goldfields. There are currently 4.1 full-time equivalents in the goldfields, and there will be an additional 8.35 staff there, giving a total of 12.45 staff. They will obviously be welcomed in the goldfields. There is \$3.5 million for the great southern. There are currently three FTE there, and that number will be lifted to 11.45 after the investment. There will be \$4.4 million invested in the Kimberley. There are currently 3.5 FTE, and that will be increased to 13.45 FTE after the investment. There will be \$4 million invested in the midwest and Gascoyne. Currently there are 2.7 FTE, and there will be another 10.85 added, lifting that to 13.55 FTE. There will be \$4.9 million invested in the Pilbara. There is currently only 1.65 FTE, which I think is quite alarming for the Pilbara, but there will be an additional 11.8 FTE, giving a total of 13.45 FTE. There will be \$2.5 million invested in the south west. Currently there are 11 FTE in the south west and that will be lifted to 16.9 FTE. There will be \$2.7 million invested in the wheatbelt. There are currently 5.3 FTE and they will be lifted to 11.45 FTE. We will see a total investment of around \$224 million over a four-year period, which equates to around \$56 million a year. In the view of the University of Notre Dame's chair of palliative medicine research, Professor David Kissane, the state needs an extra \$100 million a year to be spent on palliative care on top of the extra \$41 million announced in the state budget. The amount of \$41 million equates to just \$10.25 million per annum, and we need a total of \$110.25 million per annum. At the moment, we are looking at \$56 million per annum, so we have a shortfall of around \$54.25 million each year. Clearly, we are short of the extra investment that we need in palliative care.

In an article on WAtoday of 3 September 2019, titled "Polling reveals that country voters want palliative care fixed before euthanasia legalised", Dr Anil Tandon, chair of Western Australian Palliative Medicine Specialist Group, and a visiting palliative physician in regional areas of WA, is quoted as saying —

"Regional Western Australians should be incredibly concerned by the current level of funding directed to palliative care ...

"WA has the fewest number of palliative care specialists per capita, the lowest number of publicly-funded palliative care beds, and only one-in-three people who could benefit from specialist palliative care has access to the services they need.

It has been well documented that states with the worst palliative care systems are often the most supportive of euthanasia, and this is clearly evident with Victoria legalising assisted dying this year and WA not far behind with the introduction of the bill before us.

The “My Life, My Choice” report quotes Associate Professor Ian Haines, MBBS, a medical oncologist and palliative medicine specialist. He wrote —

As an oncologist with 35 years’ full-time experience, I have seen palliative care reach the point where the terminally ill can die with equal or more dignity than euthanasia will provide. It is now very effective and increasingly available for two of the three possible ways of dying, outside of sudden unexpected death, which are advanced cancer and chronic relapsing and remitting organ-specific disease such as heart or lung failure. Palliative care is also available for people with chronic progressive cognitive diseases such as dementia. This is the fourth way of dying and perhaps the most feared of all. Like Andrew Denton and others who have observed unbearable suffering in loved ones and the terrible failures of modern medicine in the past, I had once believed that euthanasia was the only humane solution. I no longer believe that.

Before we consider legalising euthanasia, we must first have a well-funded, well-functioning palliative care system in this state. This sentiment was echoed clearly in a study conducted by the WA Palliative Medicine Specialist Group, which found that 73 per cent of people living in the agricultural, mining and pastoral regions believed that palliative care should be improved before the introduction of assisted dying legislation.

In a WAtoday article published on 3 September this year, Dr Anil Tandon was reported as saying —

No terminally ill person should ever find themselves in the position of being unable to experience quality palliative care but able to access assisted dying.

This is one of my primary concerns, members: the election to access euthanasia is predicated on a lack of comprehensive palliative care. People see what their loved ones go through as they die in a system that is not resourced to support them. It is an end that they do not want for themselves, and therefore they see assisted dying as a better alternative. A poll conducted for *The West Australian* in November last year revealed that nine out of 10 Australians supported euthanasia. An overwhelming 93 per cent of people aged between 50 and 59 years said that they would want to be allowed to end their own lives with medical assistance if they were terminally ill with a condition causing intolerable suffering; however, only one in five people aged over 70 surveyed said that they would not want to have that option if they were terminally ill and suffering—the highest rate of opposition of any age group. It is interesting to point out that the poll supporting euthanasia was run in November last year, which was eight months before the bill was introduced into Parliament in July this year. It is also interesting to note that people aged 70 years and over, who would be expected to support such legislation, were less likely to want to have the option of assisted dying available to them if they were terminally ill and suffering. They counted for the highest rate of opposition of any age group in the poll. I have significant concern about supporters of assisted dying who have referenced polls and said that between 80 per cent and 88 per cent of our community support the proposed legislation. To my knowledge, prior to the release of this bill, two polls were conducted; one by Go Gentle Australia, which indicated that 81 per cent were in favour, and the second by Dying For Choice, which indicated that 88 per cent of people are in favour of euthanasia. Both organisations are dedicated to euthanasia legislation. I do not know what questions were asked in the survey or how the participants were questioned about the bill, but I can safely say that neither of those organisations are independent. As Hon Martin Pritchard said in his contribution on Tuesday evening last week, polling questions are often designed according to the desired outcome. I do not put a lot of weight on polling results. If we believed the polls, Hillary Clinton would be the US President and we would have a federal Labor government. The polls got those things wrong. My office carried out its own assessment by collating all the correspondence it received, and the results were quite surprising. The number of people in support of assisted dying, but not necessarily of the bill because I got a lot of emails prior to the introduction of the bill, is 37 per cent. Sixty-three per cent of correspondence that I received is against assisted dying, which does not seem consistent with what a lot of other members received, but that is what my office received. Of the 37 per cent of correspondents who support assisted dying, more than half referenced the polls and the alleged 80 to 88 per cent in support as a reason for me to support the bill. Ironically, a number of supporters of assisted dying have urged me to support and respect the view of my constituency. I have had the same emails as other members demanding that I vote a particular way because they are my constituents. But, of course, constituents have varying views and they all have to be weighed up. Some who support this bill believe that they should be able to access assisted dying for loved ones because of the anguish they themselves go through while watching them go through the dying process in the last six or 12 months of their life. Many members received hundreds of letters and I am sure some members have received this particular one, but because it stands out to me, I will put it on the record in this place. I received the letter in September this year from a registered nurse. It states in part —

... I have, over all my years of nursing, cared for people in their last days, and for those who had reached the limits of possible treatment and needed care to alleviate their suffering. Over these years the vast majority of dying patients have had peaceful and gentle deaths without intervention to hasten death; in a minority of patients death has been painful but in most of these instances this has been due to either intervention by families refusing to accept the reality that death is imminent and demanding active

treatment which has become burdensome for the patient, or failure of doctors to perceive that the limits of treatment have been reached.

It has also been my experience that in many instances the family suffer far more than the patient, and they tend to project their suffering on to the patient. I have on occasion counselled family on this and had conversations about their impending loss, and on occasion families have thanked me after the death, for the conversation.

In this day and age people do not have the stoicism which we saw in previous times; people want outcomes, one way or another, at once. I have had on the odd occasion a patient ask me if we can hasten the death, and I tell them honestly “no”, but then I tell them what we can and will do to make it easier and I always promise them that we will not let them suffer. In every instance, in my own experience, the patient has been reassured and has died peacefully not long afterwards. More frequently I have been asked by family at the bedside “Can’t you hurry this up?” They know they are losing their loved one so now all they want is for it to be over; very often the patient is not conscious and is painfree and undistressed.

It used to be accepted wisdom that we should not make important decisions swayed by emotion. From the very initiation of this proposed legislation, Mr McGowan, the media, some doctors, so called celebrities and other advocates of “assisted dying” have used emotion to try to persuade the public and the Parliament that this is the “compassionate” thing to do. It is not, and it is open to abuse in spite of Mr McGowan’s assurances. Already he has boasted that this legislation goes further than the recommendations of his Ministerial Expert Committee, and further than the Victorian legislation. The proposed legislation has been brought forward through its various stages in haste, minimal publicity or opportunity for comment has been provided to those who do not support the legislation and we are told that “88%” of people support it; I have my doubts about that as I cannot find one person in my workplace who does!

The bill has been presented on the premise that people do not want to suffer at the end of life. I am sure that no-one wants to suffer at the end of life and I am sure that their loved ones do not want them to suffer at the end of life. I feel that palliative care can play an important role in minimising that suffering.

A 6 July 2017 article titled “Viewpoints: Should euthanasia be available for people with existential suffering”, which was published on The Conversation website, states —

A 2011 study of Dutch patients who requested euthanasia indicated that “hopelessness”—the psychological and existential realisation one’s health situation will never improve—was the predominant motivation of patients who requested euthanasia.

And a recently published Canadian study of requests for medical assistance in dying stated “loss of autonomy was the primary reason” motivating patients to end their lives. Symptoms also included “the wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one’s life”.

There have obviously been quite a lot of news articles about this issue in recent times. On 7 August, in an ABC news website article titled “Voluntary euthanasia legislation appears likely to be passed”, Mr McGowan was reported as saying —

It’s time for the Parliament to do the right thing by people and families who are going through enormous pain, who are terminally ill ...

In a 25 September *The West Australian* article titled “VAD laws clear first hurdle”, Premier Mark McGowan urged the public to pressure their local members to make their voice heard. The article states —

“Tell them you do not want this issue to drag on unresolved,” ...

It also stated —

“When you look back on your career as a parliamentarian, make sure you look back with joy, that you did something good, that you believed in. —

I will comment on that a little later in my contribution —

That you were not bound by party lines. That you did not give in to those that would bully or intimidate. The factional powerbrokers.”

I am not quite sure who he is referring to.

In a 25 September *WAtoday* article titled “Euthanasia bill survives Lower House intact as Premier raises spectre of ‘factional powerbrokers’”, the Premier is quoted as saying —

The euthanasia legislation did not require amendment or “further frustration and delay from an additional inquiry”.

The fact of the matter is that the Legislative Council has a role to play in reviewing legislation. I find it appalling that it has been indicated that we should let this bill sail through without scrutiny. Our job is to review legislation. Quite a lot of legislation has come to this place over the last couple of years to which amendments have been made and the legislation improved to better serve the Western Australian community and it has gone back to the Legislative Assembly. I do not know why we should rubberstamp this bill. WA today's follow-up story on 26 September is titled "WA euthanasia debate: Premier accused of lying over bullying comments" and it quotes the Premier as saying —

"Make your own mind up on this, do what you think is right and listen to your community."

I have listened to the community.

A 14 October *The West Australian* article, "Assisted dying critics are 'cowards'", quoted Premier Mark McGowan. I find that very disrespectful in this debate. He is quoted as saying —

"To politically delay and frustrate this Bill, is to needlessly prolong the suffering of other Western Australians,"

...

"Worse still, to prevent a vote is undemocratic and cowardly."

I take great offence to that. The democratic process in here means that people can have differences of opinion. We debate that in this place and we scrutinise legislation and things are put to the vote. That is how it works.

An article in *The West Australian* dated 13 October, headed "Backbenchers cop raw deal", includes comments from Labor MP Margaret Quirk, who stated that there was clear "implicit" pressure on herself and her colleagues to support the bill's smooth passage. I must say that Margaret Quirk has a very strong political backbone for being able to stand up to this. She said —

"Certainly I know of a number of occasions where members sought to speak in favour of the Bill and were asked ... not to speak to expedite the process of the Bill through the Lower House," ...

That really highlights to me that a lot is going on when it comes to this being a conscience vote.

Contrast that comment with the Premier's comment published on 25 September, in which he warned against being bound by party lines and not giving into those who bully or intimidate. A 15 October ABC news article headed "Crunch time as assisted dying Bill goes to Upper House" quotes Premier McGowan; he said —

"I urge people to vote for it, the public is overwhelmingly in favour and that the Parliament should reflect the view of the public," ...

The Premier tells us to make up our own minds, and then in another breath calls us cowards. This bill is being pushed by a government in an environment in which increasingly a number of baby boomers are aging and being diagnosed with diseases, illnesses and medical conditions for which there is inadequate infrastructure in place for them as far as palliative care is concerned. According to the federal Treasury, the number of Australians aged 65 years and over is expected to increase rapidly from 2.5 million in 2002 to 6.2 million in 2042. For Australians aged 85 years and over, the growth is even more rapid—from 300 000 in 2002 to 1.1 million in 2042. It has been reported that by 2042, there will be only 2.5 people of working age to support every person over aged 65 or over.

The Australian Medical Association (WA) has been opposed to legislation that allows for the termination of life. On 6PR on 6 August the immediate past president of the WA AMA, Dr Omar Khorshid, stated that this bill is a rushed job; it looks a little unworkable; and it looks a little naive. He said that it is clearly not written for people who understand how our health system works, and that there is a long way to go before we can make this both safe and effective legislation. On 23 August 2019, on page 9 of *The West Australian*, the Australian Medical Association WA's new president, Andrew Miller, said —

"We don't want to see this Bill passed as it is now because we don't feel the safeguards are anywhere near as good as Victoria."

I know the government has cited the many safeguards and latches that are in this legislation to make it safe from exploitation, but there are far greater risks in the massive cultural shift that we are about to embark on from what we currently have, which is the preservation of life to one that is a government-sanctioned termination of life. I will talk about that a little later.

The government assures the public that it has consulted widely, yet many medical practitioners of this state are not comfortable with what they will be mandated to perform. Nonetheless, we have this bill in front of us, and, as such, we must address it. Clause 4(1)(f) reads —

a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

I have a fundamental problem with the doctors of the state being able to start the conversation about assisted dying with patients as that in itself could make vulnerable people choose this option for a number of reasons, such as fear, not wanting to be a burden on their family and the fact that they might not have a lot of savings to pay for treatment. Hon Martin Pritchard has some amendments on the supplementary notice paper, one of which proposes to prevent medical practitioners from raising it. I call it the “Buti amendment”, because that is pretty much what it was in the other place, and it was defeated. But I foreshadow that should the honourable member move that amendment, I would certainly support it.

Merely having legislation that allows, encourages and promotes assisted dying, opens it up to abuse at many stages of the process—abuse in terms of coercing patients to end their life by medical institutions, doctors, insurance companies, family and carers. The coercion will be unpoliced, unreported and unmanaged.

According to an article in the *Internal Medicine Journal*, a 1998 study found that doctors who are cost conscious and practice “resource-conserving medicine” are significantly more likely to write a lethal prescription for terminally ill patients, which suggests that medical costs influence doctor’s opinion. Paul Young, a paediatrician in Wisconsin, in his testimony against physician assisted suicide on 8 April 2008 for Wisconsin Right to Life, stated, according to my notes —

The single greatest pressure on healthcare today is financial.

As we seek to grapple with the staggering costs of healthcare, we need to avoid undermining the very ethical principles that promote good patient care.

If we allow physician assisted suicide, we may find out that we have effectively limited our approach to the palliation of chronic illness.

Unfortunately, it is cheaper to help a patient to die than to provide good end of life care.

Physician assisted suicide could encourage a patient to die as a ‘duty’ to his or her family, in the face of financial pressure.

Likewise doctors could find their end of life care options curtailed by third party payers ...

On 31 May 2017, *The Washington Times*, reported that a Nevada physician said that insurance companies in states in which assisted suicide is legal have refused to cover expenses. An associate professor of internal medicine at the University of Nevada tried to transfer two patients to California and Oregon for procedures not performed at his hospital. Representatives from two different insurance companies denied those transfer requests by phone. In both cases, the insurance medical director said, “We are not going to cover the procedure or the transfer, but would you consider assisted suicide?” The patients were not terminal but would have become terminal with that procedure.

Members, vulnerable people within our community need to be protected. It concerns me that this bill will not prevent or limit the power that some people might be able to use for coercion. I will focus my comments on the elderly within our community, but the same argument can be used for other at-risk groups. To illustrate my concerns, I will use, as an example, the older baby boomer generation we have today. Most of those individuals have the status of older person as defined in the final report of the Select Committee into Elder Abuse, “‘I never thought it would happen to me’: When trust is broken”, released in September last year. For Aboriginal and Torres Strait Islanders over the age of 55 years and non-Aboriginal and Torres Strait Islander people aged 65 years or older, according to the World Health Organization, elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person. It can be in various forms—physical, psychological, emotional, sexual, financial or simply reflect intentional or unintentional neglect. It is estimated that between 2.2 per cent and 14 per cent of older people in high or middle income countries experience elder abuse in the community, excluding elder abuse that may occur in institutional care.

According to the elder abuse report, potentially 75 000 older people in WA are affected by elder abuse. Financial elder abuse accounts for 34.2 per cent of cases; psychological elder abuse accounts for 34.2 per cent. Research suggests that both forms of abuse frequently occur simultaneously. So who are the perpetrators? According to Seniors Rights Victoria, two-thirds of elder abuse incidents that occurred in Victoria were perpetrated by a son or daughter of the older person, with over 92 per cent of perpetrators being related to the victim—40 per cent were sons, 26.8 per cent were daughters, 4.8 per cent were husbands, 3.3 per cent were wives, 3.1 per cent were de facto partners, 4.4 per cent were grandchildren, 3.3 per cent were sons-in-law, and 3.1 per cent were daughters-in-law. The committee identified seven main risk factors, with an older person being more likely to experience elder abuse if they are a woman; are an Aboriginal or Torres Strait Islander person; have a cognitive impairment or disability; are a member of a culturally and linguistically diverse community; identify as lesbian, gay, bisexual, transgender, or intersex; are experiencing social isolation or loneliness; or are being cared for by a person who is experiencing carer stress.

According to the elder abuse report, enduring powers of attorney and enduring powers of guardianship are significant tools that can be used as a means to perpetrate elder abuse on vulnerable older people. This is supported

by the Office of the Public Advocate’s submission to the committee, which indicated that 211 allegations of elder abuse were investigated during the 2016–17 financial year. Allegations of abuse were a factor for 124 represented people in guardianship applications, and 51 people in that group were 65 years of age or older. Older people are also more likely than younger people to have a disability or severe core activity limitation. In 2015, just over 50 per cent of all older people had a disability, and 36.4 per cent of those adults had a severe or profound activity limitation. According to the Australian Institute of Family Studies, as the proportion of people aged 65 years and over increases over time, the overall population of older people vulnerable to abuse is expected to increase with it. The Australian Institute of Family Studies report titled “Elder Abuse: Key Issues and Emerging Evidence”, in Child Family Community Australia paper 51, states —

The abuse of older people negatively impacts the victims in a range of ways ... elder abuse has the common effect of reducing an older person’s quality of life.

The impact of abuse, like the abuse itself, can often go undetected and is difficult to quantify ... victims of elder abuse experienced higher rates of depression, post-traumatic stress disorder, anxiety and poor health ...

We might ask what that has to do with voluntary assisted dying. We know that elder abuse is happening. We know that it takes place on a financial and psychological level, and we know that it is taking place in family settings. The bill provides a perfect environment for a patient to be subjected to the ultimate elder abuse, which is their death. Although the bill does not allow a family member or someone who may benefit from a patient dying to be a witness to the patient requesting access to assisted dying, I have not identified anything in the bill that prevents a family member or someone who may benefit from the death from being a contact person. I do not know whether a family member or someone who will somehow benefit financially from a person’s death is excluded from being a contact person. The role of the contact person under clause 66 is to receive the prescribed substance from the authorised supplier, possess the substance and supply the substance to the patient. The bill does not make provision to ensure that the contact person, who will play a crucial part in the patient’s end of life, is of sound mind, does not suffer from carer fatigue and will not financially or otherwise benefit from the patient dying. Clause 15(1) of the bill provides the following eligibility criteria for a person to access assisted dying —

- (a) the person has reached 18 years of age;
- (b) the person —
 - (i) is an Australian citizen or permanent resident; and
 - (ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;
- (c) the person is diagnosed with at least 1 disease, illness or medical condition that —
 - (i) is advanced, progressive and will cause death; and
 - (ii) will, on the balance of probabilities, cause death within a period of 6 months or, in the case of a disease, illness or medical condition that is neurodegenerative, within a period of 12 months; and
 - (iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;
- (d) the person has decision-making capacity in relation to voluntary assisted dying;
- (e) the person is acting voluntarily and without coercion;
- (f) the person’s request for access to voluntary assisted dying is enduring.

Clause 15(2) reads —

A person is not eligible for access to voluntary assisted dying only because the person has a disability or is diagnosed with a mental illness (as defined in the *Mental Health Act 2014* section 4).

I will expand on that a little further on in my contribution.

Most people who will support this bill would do so with the above provisions, but would they support this legislation if the criteria for eligibility were loosened, as has been the case around the world? In a WAtoday article on 16 September, Professor David Kissane, a prominent psychiatrist, was quoted as saying —

“We’ll see gradually the development of what happens in other countries, where in Canada there is now a debate about the mentally ill accessing euthanasia.

“In the Netherlands and Belgium, the mentally ill do access euthanasia and it’s given to adolescents with autism, it’s given for people with anorexia, it’s given for schizophrenia and depression.”

I think it would be naive to think that this bill will not be open to future pressure to expand the scope of those who would qualify for euthanasia. If we truly support the clause 4(1)(a) principle that every human life has equal value,

it will just be a matter of time before assisted dying will be available to any person of any age, with any condition they felt was unbearable. This is my primary concern with the legislation before us—the major cultural shift from the absolute preservation of life that we have now to one in which we will have government-sanctioned termination of a life. I have no doubt that in the future—it will not be this Parliament but it may be the next Parliament or the one after that; some of us might still be here, and some of us will no longer be in this place—interest groups will be lobbying the government to be included in the groups eligible for access to euthanasia. This has taken place in other countries. The Netherlands legalised euthanasia, including physician-assisted suicide, in 2001. Four years later, in 2004, the Groningen Protocol was created, containing directives with criteria under which physicians can perform child euthanasia without fear of legal prosecution. Belgium legalised euthanasia for terminally ill adults in 2002. Twelve years later, in 2014, it amended this legislation to allow euthanasia for minors, regardless of age. In 2019, it was reported that three children had been killed by euthanasia in the past two years. In February 2010, a citizens' initiative called Out of Free Will demanded that all Dutch people over 70 years of age who feel tired of life should have the right to professional help to end their lives. In 2016, the Dutch health minister announced plans to draft a law that would allow assisted suicide in cases of terminal illness if a person feels they have completed their life.

Although this bill does not allow a mentally ill person to access assisted dying, I am sure that, with time, that will open up to them. Given that there is no requirement for mandatory psychiatric examination of a patient, how can either of two medical practitioners be sure that there is no underlying mental illness affecting the decision to access assisted dying? Sometimes, the decision-making capacity is limited in persons who have a mental illness that is persistent or temporary due to a tragic event in their lives. Those individuals should be given access to professional mental health care rather than a highway to assisted dying, which, in their desperate state, they would no doubt take.

A special report by Dr Laura Dunn published in the *Psychiatric Times* in 2017 found that the three most frequently mentioned end-of-life concerns were decreased ability to participate in activities that made life enjoyable, loss of autonomy, and loss of dignity. Dr Dunn claims that these are mental health issues that psychiatrists and psychologists are meant to treat. It has been reported that the desire to suicide often departs once mental illness and pain are effectively treated, even in the terminally ill.

I worry about the future of this legislation, and what that might mean for our community in the years to come. To illustrate that point, in 2018, Aurelia Brouwers, aged 29 years, was allowed to access assisted dying in the Netherlands, which permits end of life when there is unbearable suffering without hope of relief. Her death has triggered a fierce debate in a country that has one of the most permissive euthanasia laws in the world, because not only was she young, but she did not have a terminal disease. She suffered from psychiatric illnesses.

Members, when it comes to mental health, that is something that for me is quite personal. I have heard a number of stories in this place from members who have had loved ones pass away. I feel that those members had a lot of courage to be able to express that in this place. There are a lot of parallels in those stories for me with family members who have passed away over the years, except for one. I agonised over whether I would share that in this place, and, under wise counsel from my staff, I will not, save to say that when someone has a tragic event in their life, and they go to the depths of despair, grief and hopelessness, with what they see as no way out, I am convinced that if the option to end their life were available to them, they would take it. This can go on for years. I have a very raw and personal experience of this. Ending their life would deny them the opportunity in later years—as has been the case, fortunately, for me—to find joy in life, to find love and live a good life. It really, really worries me that, in time, the scope of this bill would be opened up to people who are experiencing severe depression and mental health issues. I had more to say about that in my contribution today, but I will leave that there, members.

I have looked at some of the *Hansard* debates and at some of the commentary around Australia on the issue of life choices and euthanasia, particularly in Victoria. I know that this has already been quoted in this place, but I will quote it again, because it captures things quite well. I refer to an article in *The Sydney Morning Herald* of 19 October 2017 written by former Labor Party Prime Minister Paul Keating—that rascal of a Prime Minister, who was very good at capturing situations with just a few words. Paul Keating is quoted as having said —

The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients.

He said also —

An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project—the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.

No law and no process can achieve that objective. ... If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system. Beyond that, once termination of

life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law.

...

The experience of overseas jurisdictions suggest the pressures for further liberalisation are irresistible.

Paul Keating concludes the article by stating —

The issue is not how many people will choose to die under this proposed law. It is how many people may die when otherwise they wouldn't.

I relate to that quite strongly, members. During this debate, I have listened to other members raise certain issues, particularly around Indigenous Western Australians. I note that Hon Ken Baston in his very fine contribution last Thursday touched on that very issue. I refer to *Hansard*, in which he states —

The member for Kimberley, Josie Farrer, also made important points about what needs to be done to improve the delivery of health services in the regions, particularly for Aboriginal people and people who live in extremely remote communities. I can say now that if this legislation passes, a lot of work will need to be done to ensure that there is adequate engagement with Aboriginal communities to make sure that it does not erode the delicate levels of trust that currently exist between health service providers and Aboriginal people living in very remote communities.

This area certainly needs further investigation. I think there is a gap in the way this has been proposed. I know that the Minister for Health is looking at establishing a task force to try to deal with this. Some work needs to be done on it. Hon Colin Tincknell also made mention of this in his contribution last Wednesday, when he said —

Australia's two most prominent Aboriginal politicians have opposed this bill and talked about their concerns. They and other government members say that the consultation has not been to the standard they would like. It is not easy to talk about Aboriginal health or culture. Number one, Aboriginal people look at health and death and many other things in society quite differently from us. There are 100 000 Indigenous people in this state and it is not a matter of just consulting with them. We need to help them understand, and until they understand, we have some issues.

I agree with those sentiments. I will back that up by referring to an opinion piece that was published in *The Australian* in October this year. A lot of this relates a speech in the federal Parliament in August 2018 by Senator Pat Dodson. I am sorry, but members will have to bear with me, because I want to read right through this to make a point. The article states —

Writing in *The Weekend Australian*, Senator Dodson says legislation passed in the lower house of the West Australian parliament lacks indigenous input and could backfire if enacted.

"Fears and suspicions of 'whitefella' medicine will only increase, and the capacity to ascertain informed consent will be difficult," Senator Dodson writes.

The state is the second after Victoria to bring forward a government-backed bill for voluntary assisted dying ... while a parliamentary committee in Queensland is well-advanced on assessing the case for legislation there.

Liberal-governed South Australia is also eyeing reform, two decades after VAD became law in the Northern Territory but was voided by John Howard's federal government.

The Northern Territory experience in the 1990s suggests that the mere presence of this legislation may be a barrier to First Nations peoples receiving healthcare," Senator Dodson writes.

He says supporters of the bill—"most with good intentions and compassion for loved ones"—are building their case on an individualist rights agenda.

"Such a perspective emphasises the rights of an individual and ignores the wider influence of such decisions on those around them—families, friends and communities," he writes.

"Individual choice is an important component of this but it should not be the only significant factor because other humans are going to be required to live with the consequences of their part in ending the life of another.

"In an increasingly atomised world, we are finding it harder than ever to understand the interconnectedness of our social structures and the political choices that hold them together."

Asked how a VAD law in his home state of Western Australia would compromise indigenous medical services, Senator Dodson said: "People are very suspicious of the whole (health) system generally. If they find it is associated with potentially the capacity to end your life, as much as to save it, I am fearful people will then, despite their need, start to move away."

Senator Dodson said his thinking on euthanasia bridged his life experience as a onetime Catholic priest, his spirituality as a Yawuru man and the founding role he played in the reconciliation movement. He agreed it was at odds with progressive sentiment in the ALP.

“I think there are things about my way of thinking that may not necessarily sit squarely with all of my comrades,” the 71-year-old said. “Then again, we live in democracy, so it’s up for debate.”

Putting forward “another avenue to death” was confronting for First Nations peoples when they lived shorter lives than other Australians, had babies that were more likely to die of preventable diseases and lost too many friends, cousins and siblings to suicide. “As representatives and legislators, surely we must be focusing our attention to enacting laws that help prolong life and restore the right to enjoy a healthy life,” he said.

Senator Dodson said the WA legislation contained “significant deficiencies” in terms of content and process. A key provision in the benchmark Victorian law that came into effect in June, banning doctors from raising VAD, had been reversed in an error by Perth’s lawmakers, he insisted.

Asked what was wrong with a doctor broaching assisted dying with a terminally ill patient, he said: “This is a fine line where the reservoir of knowledge is deemed to be in the professional, when in fact this is about someone else’s life. This is about an individual having to weigh up and consider whether this is an option they really want to take.

“Now, to instigate that discussion ... requires a broader context for First Nations people. They are not just nuclear families ... most of us have extended families and not everyone in those relationships see eye to eye. It’s about reaching consensus on the way forward that enables communities to stay together, rather than ones that simply decide they are going to allow individuals to make decisions for everyone else.

“If it’s then removed off to a doctor without any reference to the community about him initiating discussions with the loved one, then I think that also starts to undermine ... the trust you place in a medical system to look after your health rather than find ways to end your life.”

The consultation with indigenous communities was not only inadequate but rushed, Senator Dodson said. “This is a matter that should be done over a period of time ... one meeting, setting up a forum in one community ... that’s not a way to really consult with First Nations people on a complicated issue like this, that is about the sanctity of life itself, not just about an individual’s life,” he said.

His intervention came after recent polling in Western Australia showed that nearly three-quarters of those living in regional and remote areas of the state supported improved access to palliative care over voluntary euthanasia. The research, for the End of Life Choices Working Group backed by palliative care specialists, found that 56 per cent of the 1 900 respondents didn’t believe patients should be helped to die without their loved ones being informed—another point of contention in the WA legislation.

The Anglican bishop of North Queensland, Keith Joseph, told a committee of state MPs in August that remote indigenous communities were strongly opposed to VAD, echoing Senator Dodson on its potential to erode trust in the public health system.

The WA bill cleared the Legislative Assembly last month by 44 votes to 12, but the numbers will tighten in the upper house. Proponents remain confident the legislation will pass, albeit narrowly.

Senator Dodson agreed the debate was being conducted piecemeal, siloed in state legislatures, with no regard to how state regimes would interact.

Members, based on that, I also am very concerned about the impact on communities in very remote and regional Western Australia. I think a lot more work needs to be done around that area. I do not know that having a task force that will visit people is the way to go. I know that this Voluntary Assisted Dying Bill 2019 provides for telehealth to assist with assessing patients but I understand that federal legislation might prevent that, so that if a doctor does that, they could find themselves exposed to litigation. With that, I wish to move a referral.

Discharge of Order and Referral to Standing Committee on Legislation — Motion

HON RICK MAZZA (Agricultural) [4.04 pm] — without notice: I move —

- (1) That the Voluntary Assisted Dying Bill 2019 be discharged and referred to the Standing Committee on Legislation for consideration and report no later than Tuesday, 11 February 2020.
- (2) The committee has the power to inquire into and report on the policy of the bill.
- (3) The committee is instructed to undertake the following in its inquiry —

- (a) consult with and take evidence from Indigenous persons including those residing in regional and remote communities in the state;
- (b) investigate the provision of palliative care for Indigenous persons residing in regional and remote communities in the state; and
- (c) report on whether the bill provides for culturally appropriate end-of-life choices for Indigenous persons.

HON SUE ELLERY (South Metropolitan — Leader of the House) [4.05 pm]: I oppose the referral to the Standing Committee on Legislation. This is a conscience vote, and that means that, ultimately, we and only we will have to make the final decision about how we vote on each of the various elements of the bill, be those policy elements or, indeed, procedural elements such as the decision about whether we refer to committee. In any of those matters related to this debate, be they policy, technical, legal, clinical, or in this case cultural, we have all observed there are different points of view. With the greatest respect to Senator Dodson, not only one voice speaks for all Indigenous people. We have observed that there are different views. There are different, deeply thought-out views but, ultimately, different and opposed points of view. Although a committee may collect material, seek submissions and hear from experts or others, no committee can ultimately resolve the points of view that are different between us. It will come back here and we will have to make a decision, and consider what it said and cast our votes ourselves. Equally, this matter, including whether there has been adequate consideration of cultural matters, has been subject to widespread public discussion. Indeed, we have just heard that Senator Dodson himself wrote a public opinion piece. Any member who has had any question or any query about any element of the Voluntary Assisted Dying Bill 2019, as it is before us, has had and still has a very wide range of opinions they can seek and a very wide range of experts that they can contact themselves. They can seek that information directly. They can seek briefings, meetings and advice in all ways. Ultimately, members have to consider that themselves and, ultimately, make their own judgement on how to vote.

The extent of public engagement in this debate has also meant any number of experts, stakeholders or lobbyists can get information to us as individual members if that is what they want to do and they have, be it legal, clinical or technical or in the case the honourable member has raised, be it cultural. I, too, have received information and views from representatives of Western Australia's Indigenous community. Those people have had the opportunity to put that to us directly through all ways. Then again, it will still come back to the individual vote of each of us weighing up that information.

I do not support a referral to the Standing Committee on Legislation. No stakeholder has not had the opportunity to put views to us through their respective representative organisations. They still have the opportunity to put views to us as this debate proceeds over the next four or five weeks that we will be debating this. There are experts and people with strongly held views on each side of each issue that we may want to raise in respect of the Voluntary Assisted Dying Bill 2019, and they are entitled to have those different points of view. But, ultimately, no committee will be able to resolve those differences. The bill will come back here and we will have to consider that material. Ultimately, each of us will have to cast our vote one way or the other, or I suppose we could choose to not exercise a vote at all, but each one of us has to make that decision.

This is hard for many people. For some members, it may be the hardest decision that they have had to make or will make in their parliamentary career. Whatever a committee explores, finds or recommends, nothing will change the fact that there are experts with different points of view and that the decision will just come back to each of us as individuals. I cannot see how a committee could resolve the differences between us, how it could resolve the differences between the experts, or how, in this case, it could resolve the differences between different members of the Indigenous community of Western Australia, who also have different points of view. I do not see how a committee could resolve those issues. Ultimately, it will come back to the 36 people in this chamber to make their individual decisions, and for those reasons, I do not support the referral.

HON NICK GOIRAN (South Metropolitan) [4.11 pm]: This feels like a case of *deja vu*, because the Leader of the House gave an almost identical speech when the house sought to refer the Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2018. I was the mover of the motion at the time, and I specifically recall the Leader of the House saying words to the same effect as those she delivered just now. In effect, she said to members, "You cannot refer this matter to a committee because it's a conscience vote. How can a committee resolve matters that are matters of conscience?" I remind the Leader of the House that on that occasion, the report came back from the committee and the government has chosen to never bring that bill on for debate ever again. Members know full well why; it is because there is a fatal flaw in that legislation. It is possible for bills that are subject to conscience votes to be brought to the Standing Committee on Legislation for it to do its work and see whether there are any flaws in the legislation that are worthy of the consideration of members. The threshold issue is a conscience vote; that is true, but that does not abrogate our responsibility as lawmakers to not pass an unsafe law. That is precisely what the legislation committee would be entrusted to do, in the event that members were agreeable to the discharge and referral of this bill to the committee, as moved by Hon Rick Mazza.

I draw to members' attention that it is not uncommon for this chamber to send bills to the Standing Committee on Legislation. I have before me a short list of the bills that have been referred to the Standing Committee on Legislation in the fortieth Parliament. I served on most of these inquiries in my capacity as deputy chair of the committee, but on two inquiries I was substituted off for another member. The list includes the Sentence Administration Amendment Bill 2017; the Animal Welfare Amendment Bill 2017; proposed part 12 of the Strata Titles Amendment Bill 2018; the Residential Tenancies Legislation Amendment (Family Violence) Bill 2018; the Residential Parks (Long-stay Tenants) Amendment Bill 2018; the Human Reproductive Technology and Surrogacy Legislation Amendment Bill 2018; and the Ticket Scalping Bill 2018.

I put it to members that for none of those bills that we agreed as a chamber should be referred to the Standing Committee on Legislation were the stakes as high as they are with this legislation. It would say a lot about this chamber if we were prepared to send the Animal Welfare Amendment Bill 2017 to the Standing Committee on Legislation for investigation, but we were not prepared to send the Voluntary Assisted Dying Bill 2019 to the legislation committee for consideration. I might add that we were quite happy to send the Ticket Scalping Bill to the Standing Committee on Legislation for consideration. Whatever people might think about the importance of ticket scalping in Western Australia, I suggest that the stakes are not quite as high as they are in a situation in which a medical practitioner is going to take the life of a Western Australian, whether that be with the consent of the individual or otherwise.

The context of the bill before us is worthy of consideration. I put it to members that that is an additional reason that this bill should be sent to the committee. I remind members that the genesis of this bill was the Joint Select Committee on End of Life Choices' report "My Life, My Choice". Members will recall that that committee was asked by this chamber and the other place to consider certain things in accordance with its terms of reference. Members will also recall that I asked the chamber to insert an extra term of reference for the committee to consider the risks of voluntary assisted dying. We were implored by one of the ministers of the Crown to vote against that term of reference. Consequently, it is a matter of public record that the Joint Select Committee on End of Life Choices did not look into wrongful deaths in other jurisdictions. It is also a matter of public record that despite the fact that the committee was asked to look into the intersection with federal law, it did not do so. To this day, more than 12 months later, I am still waiting for a member of the government to point out to me the provisions in the "My Life, My Choice" report that look at the intersection with federal law. Despite the fact that the committee was asked to do that, it was not done. I remind members that the committee minutes have been kept secret. I remind members that the Ministerial Expert Panel on Voluntary Assisted Dying told Western Australians, "We don't want to hear from you if you have an opposing view to us. You can only speak to us and provide views if you are going to accept voluntary assisted dying." The Ministerial Expert Panel on Voluntary Assisted Dying told the people of Western Australia, "Tell us how it's going to work." I remind members that the bill that is before the house was drafted by the government prior to the Ministerial Expert Panel on Voluntary Assisted Dying handing down its report. I remind members that Senator Patrick Dodson has said that there has been inadequate consultation. I remind members that the government in the other place refused to accept any amendments to the bill. If members examine their conscience, they know full well that members in the other place were instructed to not accept any amendments under any circumstances.

I point to comments made today by the Minister for Health, Hon Roger Cook, who has proceeded to tell the people of Western Australia, the media and this chamber that if we dare consider the possibility of a specialist being involved in this process, that will apparently be a deal-breaker. To say to this chamber that it will be a deal-breaker if we want to get a specialist involved because two general practitioners might make a mistake, misdiagnose and get the prognosis wrong is not only the height of arrogance from the Minister for Health, but also reckless behaviour. These are the types of things that the committee would look at.

Speaking of the Minister for Health, I refer to debate in the other place on 3 September 2019. At page 6311 of *Hansard*, he said —

Members, particularly the member for Kimberley and the member for Kalgoorlie, raised the point that some Aboriginal communities experience a lack of access to culturally appropriate local palliative care and that it is important for Aboriginal people to be given the opportunity to die on country, and for the configuration of those services to take into account collective decision-making.

That comment alone by the health minister in the other place raises a number of questions that the Standing Committee on Legislation could consider. Certainly, if I had the opportunity to serve on the committee as the deputy chair, I would ask the government what was being done to address the lack of access in Aboriginal communities to culturally appropriate local palliative care, precisely one of the things that Hon Rick Mazza is asking that committee to look into. Has the government established where the gaps in this access exist? Has the government determined the plan to address the issue of lack of access to culturally appropriate local palliative care for Aboriginal communities in Western Australia? Indeed, how many Indigenous palliative care nurse practitioners are there in Western Australia,

and in which regions do these palliative care nurse practitioners operate? My guess is that there are zero palliative care nurse practitioners. I understand that there are only about four or five in the entire state, so I still do not know how it is possible for the Minister for Health to say what he said with all seriousness. Indeed, if the matter goes to the committee, I would ask the government to what extent it had consulted with Aboriginal communities to determine how best the culturally appropriate palliative care services could take into account collective decision-making.

In addition to that, on the same day, 3 September this year, the health minister made these remarks —

I anticipate that the implementation will establish a care navigator service to ensure that the needs of Aboriginal people are identified and provided for in the operation of the bill. The Department of Health is already considering the development of a care navigator model similar to that used in Victoria, with a focus on enabling access to voluntary assisted dying for people living in rural and remote areas.

That comment by the health minister, Hon Roger Cook, draws the following questions that will need to be considered by the Standing Committee on Legislation: Has the government prioritised plans to establish a care navigator service to assist Aboriginal people in accessing voluntary assisted dying ahead of addressing the current lack of access for Aboriginal people to culturally appropriate palliative care? Has the government considered the conflict that a care navigator service will have with the concerns raised in the final report of the ministerial expert panel, including issues in relation to language and translation services for Indigenous Western Australians, as well as issues of power disparity between health practitioners and Aboriginal patients and the issue of undue influence?

With all due respect to the Leader of the House, it is not only Senator Patrick Dodson who has raised concerns about this matter. I now turn to the remarks made in recent times, indeed reported on 10 October this year, some 12 days ago, speaking to the views of Australia's first Indigenous surgeon, Kelvin Kong. I refer to the article in *The Australian* titled "Euthanasia plan 'terrifies' surgeon", and I quote certain extracts of that article. It says —

Australia's first indigenous surgeon, Kelvin Kong, says he is terrified by the McGowan government's plan to let doctors suggest voluntary assisted dying, describing patients in remote areas as often so thankful to see a specialist that they are "very compliant".

Associate professor Kelvin Kong, of the Worimi people of Port Stephens, north of Newcastle in NSW, said the priority should be change that improved the treatment and survival chances of indigenous Australians with life-threatening illness.

...

While Australia's overall cancer survival rates were among the best in the world, there was a big disparity between the incidence and survival rates of Australians who were non-indigenous and Australians who were Aboriginal and Torres Strait Islander.

"We are jumping to an end-stage conversation when we haven't got all the pathways in cancer management leading up to palliative care," he said.

...

Professor Kong, an ear, nose and throat specialist —

I pause there to say that no doubt the health minister will say that the views of this individual are irrelevant because he is a specialist and that it is a deal-breaker for us to even talk about specialists —

who treats cancer patients in cities, rural towns and remote Aboriginal communities, said he was open to the concept of voluntary assisted dying laws but he believed that in terms of priorities in indigenous health, the debate was happening in the wrong order.

"If we are serious about the betterment of our mob, we really need to increase things like early interventions," he said.

As a member of the Cancer Australia Advisory Board, Professor Kong contributed to a guide for the treatment of indigenous cancer patients that encourages doctors to focus on prevention and early detection, gives them suggestions about how to get indigenous people to feel safe going to a doctor and offers tips for how to talk to an indigenous cancer patient about treatment.

Asked whether he had concerns about the proposed WA law letting a doctor instigate a conversation with an Aboriginal person about voluntary assisted dying, he said: "Yes, it terrifies me because you don't know who that doctor is.

"There are some I know would handle it well and others not. No, this is not the right thing," he said.

"Our medical training is really good at teaching us about disease, but it's not really good at teaching us an understanding of cultural complexities, particularly with our most disenfranchised people."

...

Extract from Hansard

[COUNCIL — Tuesday, 22 October 2019]

p7964c-7984a

Hon Colin Holt; Hon Matthew Swinbourn; Hon Rick Mazza; Hon Sue Ellery; Hon Nick Goiran

Farmers and indigenous people were among regional patients who were vulnerable.

“They might have waited two years to see someone. We need to take that with honour and real respect,” he said.

As Hon Rick Mazza has indicated, Senator Pat Dodson has also expressed some concerns about this matter. I will not repeat what he said, because I think Hon Rick Mazza has already outlined the views of Senator Dodson, but I add that it is not only he who has said this. I turn now to an article in *WAtoday* of 11 October, some 11 days ago, which says —

Australia’s two most prominent Aboriginal politicians—one Labor and one Liberal—have spoken out against WA’s draft euthanasia laws, raising questions about the extent of consultation with the state’s First Nations peoples.

I suspect that members are well aware of this article. Of course, not only is Senator Pat Dodson the prominent Labor Aboriginal politician referred to in the article, but the Liberal one is none other than Minister for Indigenous Australians Hon Ken Wyatt. I ask members to consider this for a moment. If the most senior Labor Aboriginal politician in Australia and the most senior Liberal Aboriginal politician both say, “Hang on, something needs to be looked at here. Our people have not been properly consulted”, should that not at the very least make us pause for a moment and consider what they have to say? Or are we so arrogant that we will just press ahead anyway and say to Mr Dodson and Mr Wyatt, “Thank you very much for your input. As key stakeholders, you have had your opportunity; your people have had their opportunity. We will not be sending this to the committee, because we think that the animal welfare bill is more important, we think that the Ticket Scalping Bill is more important, and with all due respect to you two senior, prominent Aboriginal politicians, we are pressing ahead anyway”? Is that the message that we want to send at this point of the debate? I turn to the content in the so-called Ministerial Expert Panel on Voluntary Assisted Dying and its so-called final report. I am not sure whether it is the final report of the so-called ministerial expert panel, because I received communication late last night and I do not know whether it was a supplementary part to the final report or on what authority that particular correspondence was sent. Perhaps it is not its final report. Who knows how many reports it intends to send. Let us look at what the ministerial expert panel has to say about the interests of Indigenous Western Australians in its final report.

Debate interrupted, pursuant to standing orders.

[Continued on page 7994.]