

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 28 August.

MRS L.M. HARVEY (Scarborough — Leader of the Opposition) [9.37 am]: I rise to contribute to the debate on the Voluntary Assisted Dying Bill 2019. At the outset, I will say that I am still undecided on whether or not I will support this bill. I have some questions to ask during the consideration in detail stage and I need to use that process to better understand how this system will operate. I need to understand the following: How strong are the safeguards? How can we ensure that vulnerable people are not unfairly coerced? How will this legislation be delivered in regional and remote Western Australia? How do we ensure that people with treatable mental health issues are not accessing voluntary assisted dying outside the intent of this place in passing this legislation? How will this be funded and what are the expected costs? How will the guidelines for doctors be managed?

I know that the government, which has a large majority in this place, has the numbers to pass the bill. I am not aware how the votes will fall in the Legislative Council. Nevertheless, on a conscience vote, all members have a responsibility to properly scrutinise the legislation and ensure that we mitigate any potential adverse consequences as a result of this bill becoming law.

This is a difficult issue and a very confronting debate. Each individual in this place brings forward their own life experiences and their own traumatic experience around terminal illness and loss. Indeed, the debate triggers the grief loss for most people as we contemplate this confronting issue. Debate has been raging in the community for a long time and the lobbying of members of Parliament has been relentless. I am also very conscious that my position as Leader of the Parliamentary Liberal Party has put me front and centre of this debate because of my own life experiences and the leadership position that I hold. This has caused significant pain for some of my family members when they see comments in the media that trigger our grieving process again. Although commenting on these difficult issues is part of my job, I can never be certain when photos, or even which photos, of my late husband, Hal, might pop up. I cannot always be out there alerting family members to stories that might eventuate, and, in any event, if a photo is used, it still brings the sense of loss to the fore no matter how much warning is given. I can only ask my family for their forgiveness and thank them for their understanding of the difficulties that being related to a member of Parliament brings and for their love and support regardless of the public nature of the job.

Should this legislation pass both houses of Parliament, I understand that we will be only the thirteenth jurisdiction in the world to have introduced this legislation. I am not sure whether that makes us more advanced or compassionate as a society. I have listened to many members' contributions to this debate, both in this chamber and outside this chamber through the media and other forums. The Liberal Party's position has been very clear from the outset that this would be a conscience vote for Liberal MPs. A conscience vote means that members should vote according to their own conscience, experiences and ethics, and, importantly, in consultation with the community that elects them. My expectation is that the conscience vote will reflect the views of the community on voluntary assisted dying. We are a reflection of the community that we represent. Although there appears to be majority support for voluntary assisted dying in the community, there are also those within the community who oppose it for legal, personal, religious or ethical reasons. Every view is important and valid, and should be respected. There are no right or wrong views on ethical decisions, and Parliament should rightly reflect the range of community sentiment on this issue. This debate should be respectful of all points of view.

In considering this legislation, I have read the Joint Select Committee on End of Life Choices report "My Life, My Choices" and the report from the Ministerial Expert Panel on Voluntary Assisted Dying. I have read hundreds of emails from many people from my constituency, from across WA and indeed Australia, and I have attended many briefings. I have canvassed the issue with friends and family, and feel very grateful to belong to a large family, with sisters, aunties, nieces and nephews who are nurses, and I am proud to say that I have a niece who is studying to be a doctor. We have a large and extended family, and many members have succumbed to difficult diseases—mesothelioma, pancreatic cancer, emphysema to name some. In that context, I will outline some of my concerns with the legislation that I will raise in the consideration in detail stage.

One concern I have with this bill is that there is no compulsion for people requesting VAD to have a proper mental health assessment. By that I do not mean waiting for months on a waiting list to see a psychologist or psychiatrist, but a sit down with their GP in a long appointment to discuss how they are feeling about their illness, their life, their families and relationships, and also how their illness is affecting those close to them. A good GP will be able to assess whether a person has depression. Indeed, many GPs have a diagnostic survey that they use to refer patients to a psychologist for Medicare-subsidised counselling services. Many patients who have terminal and chronic illness may have never sat down with an independent medical professional to discuss their feelings about their predicament, and I think it is important that this happens.

Extract from Hansard

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My concern about this comes from looking through the prism of my own experiences. I have, as most people know, been through the difficult, sad and traumatic experience of caring for my late husband, Hal, while he fought pancreatic cancer. By way of background, a CT scan revealed a tumour on Hal's pancreas on 30 June 2011. He had developed jaundice, which took us to the GP who ordered the CT scan. We had the scan in the morning and I received a phone call from the GP. He said, "I need to see you both, together, after the surgery closes at 6.15 pm." The dread of attending that appointment is still palpable. From there we had a series of tests followed by surgery on 12 August. The surgery could not successfully excise the tumour and, of course, the next question we had was how long. We were told to get our affairs in order and they would try to get us past Christmas. Our children were 11 and nine; my stepdaughter was in her early twenties and our grandson, Riley, just a toddler.

It was devastating news to receive. Hal sank into a funk. Understandably, he became depressed and did not want to go through the treatment. He wanted to take our family to Switzerland where he could access voluntary euthanasia. I made it very clear to him that I would not be going on a holiday to knowingly bring him home in a coffin, but I would find him a good clinical psychologist so that he could talk about how he was feeling. I also said that I wanted to be able to look our children in the eye and tell them that he had fought hard to stay with them. Hal went to see the psychologist, who said he was in a grieving process and that he was mildly depressed. She said it was normal for people to feel this way when they receive a terminal diagnosis. Hal had several sessions with her and thankfully decided that he would give treatment a go. Through those counselling sessions, he also learnt that the biggest issue for him was that having worked so hard all of his life he was never going to enjoy the retirement we had planned.

We commenced a gruelling treatment program of radiation therapy, and chemotherapy, week in week out, with regular tests to map the success or otherwise of the treatment. Waiting for test results was always incredibly stressful, and usually accompanied by many sleepless nights and heightened levels of anxiety. We also got started on bringing the retirement forward and used the next three years to use the breaks between chemotherapy treatments to take the family on Hal's retirement. He took Elizabeth and Sarah to Italy, and Jack to Papua New Guinea to fish. We all went fishing together at Scott and Seringapatam Reefs, the Kimberley rivers and False Entrance. We did the Gunbarrel Highway and the Gibb River Road, to mention a few. We did all this in the three years post-diagnosis, when his life expectancy with terminal pancreatic cancer at that time was less than six months, and he had wanted to opt out within the first six months.

My fear in not having the requirement for a mental health assessment included in this legislation is that using our family as an example we would not have had those three years of memories with our children, bearing in mind that those three years are the difference between my youngest losing their father at the ages of 14 and 12, versus 11 and nine, and Hal taking his eldest daughter down the aisle at her wedding and welcoming a second grandson, our gorgeous Orlando, into our world.

Another concern I have with this legislation is about proper safeguards for vulnerable people. Once again from my own experience, the last year of Hal's life was really difficult. Our family had the benefit of having extended support from family and friends. Hal's mum was with us every day; his sisters and families, my parents and siblings, Sarah and Shane, and an extensive network of colleagues and friends were there to support us. We met many people along the way who had little to no family support. We shared a ward in Royal Perth Hospital with a fellow who had been chronically ill for a long time. He had no sick leave left. His wife was working double shifts to pay the mortgage. The kids were overseas and not involved. He was in hospital getting visits between his wife's shifts at 9.00 to 9.30 pm. That was his life. How would VAD feel as an option for that family going through their worst moment unsupported? VAD should not be an option because of financial hardship and lack of emotional support. The legislation must contemplate providing support for individuals in those scenarios so that they only access VAD for their medical symptoms, not because of financial pressure and emotional neglect.

I am also concerned that the legislation must ensure that no-one can be coerced into accessing VAD. I know that whenever this is mentioned strong proponents charge in emphasising the words "It's voluntary; it's voluntary." We must ensure that a decision to access VAD is truly voluntary, and I will explain a little about the subtlety of coercion. Towards the end of our journey, Hal was heavily medicated. He had psychosis, which I am told is fairly common. He had lost lots of weight and weighed only 52 kilograms, having dropped from over 80 kilograms when he was diagnosed. We had visitors: friends and colleagues from the fishing community and others, who would come and visit. They were understandably upset at seeing the physical state that he was in. But Hal could not understand why they were so sad. Hal would ask, "Why the doom and gloom. I feel fine. I'm going to beat this thing." He remained so positive right until the end.

But I would be counselling friends outside his room, who would be saying, sometimes loudly enough for Hal to hear, "How can you let this keep going? I wouldn't let my dog die like this." I cannot tell you how heartbreaking and distressing it is as a carer to have your cherished family member fighting for their life while others, no doubt dealing with their own trauma and issues, were making comments like that. I would have to intervene and have conversations along the lines of, "So, is he happy?" And he always was. He had a big smile on his face for every

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visitor. Did he talk about anything other than where his next trip was going to be? Did he say he was fed up and wanted to end it? The answer was no. Despite his poor physical condition, he was not contemplating anything other than fighting the disease. Our family was only interested in supporting him through it, but for others watching, they felt he should be released from his perceived suffering.

The pressure is subtle and sometimes it is overt, but the pressure is there. I had to have these conversations not with everybody and certainly not with our devoted immediate family, but with well-meaning but ill-informed friends who could not cope with their own distress in witnessing the ravages of terminal cancer. I then had to go back into the room, draw on Hal's amazing courage, and support him through the next day. People can be very indiscreet with conversations like that. For patients, and particularly elderly patients, they might feel it is a better option, to feel less of a burden, to access VAD. That should not be possible under any regime. I accept that the government believes that the legislation will not allow this to occur, but it is still a concern, and I will need to be convinced that the legislation will contemplate managing this scenario.

There is also the issue of elder abuse and inheritance from patients. The very sad statistic that 40 per cent of elderly people in aged care have no visitors each year is disturbing. How would I feel about that—to be stuck in an aged-care facility with no family or friends bothering to check on me and having no-one care about me except paid workers? Would VAD be an option in those circumstances? Quite possibly. Is that appropriate? One would hope that a compulsory mental health check would rule that out. Many of these elderly people are on medications for heart and blood pressure and other illnesses. Should they decide to refuse those medications, their prognosis may then fit the criteria for VAD. Would this scenario be acceptable under the legislation?

I have serious reservations regarding the access and management of VAD in regional and remote areas. As has been mentioned by others, there is inequitable access or, in many places in regional and remote Western Australia, no access, to palliative care services. The parliamentary inquiry revealed the extent of this problem. It must be tackled. I accept that the government is attempting to tackle it by starting to fund that program. While I accept that funding has been allocated, there is a gap. We have a capacity problem in that there is an insufficient number of trained individuals in this important area of health care.

[Member's time extended.]

Mrs L.M. HARVEY: I would not like to be in the situation, for example, of someone who has lived in regional or remote Western Australia all of their lives who receives a terminal diagnosis and, in the absence of palliative treatment options other than in the city, chooses VAD in lieu, so that they can end their life at home rather than in a hospice in the city. The minister will need to explain how the telehealth option will work in the context of commonwealth legislation. I know he is aware of that issue.

As mentioned by the member for Dawesville, the statistics around the health of our Indigenous community are of concern. Given the prevalence of chronic illness in our Indigenous population, we will need to fully understand how VAD will work in remote and regional WA for those traditional owners who wish to die on country. Who delivers their care at end of life? How does VAD work in that setting?

I have other concerns that I will raise during the committee stage of this bill. However, one aspect that has not been adequately explained is: who will provide these services and how will they be funded? There are private palliative care providers that are unlikely to want to participate. Will the GP visits to request VAD be publicly funded or will there be out-of-pocket expenses? Will the schedule 4 and schedule 8 substances that will cause the death of those accessing VAD be funded through the pharmaceutical benefits scheme or will the patient have to pay the full cost? How much will that cost? If the PBS does not subsidise the prescription, will WA taxpayers be funding the drugs? And how do we make sure that the medication is secured properly while in the custody of the patient who wishes to access it? How can we be sure that once they have taken it home, they make the choice to use it in their own time and not at the coercion of potentially impatient relatives?

To conclude, this issue is complex and confronting. I completely understand why people want voluntary assisted dying. I respect that people want to have choice and control over the way they might die due to terminal illness. One of my sisters, who is a nurse and who joined the rally to Parliament House to support Belinda Teh, deals with utterly dreadful ulcerative head and neck cancers. I know from talking to her that while pain can be managed in most circumstances, palliative care cannot mitigate some of the horrible aspects of disease—the sheer discomfort of advanced disease. However, we must also realise that for most people with advanced disease, pain and symptoms can be managed comfortably. The fear people have of end-stage disease and death is what drives the push for voluntary assisted dying.

I am haunted by the words of our wonderful palliative care nurse, Lou, who has worked in the palliative care sector for over 27 years. She said that in all that time, she has had three patients who wanted to have access to voluntary assisted dying. She said their circumstances were utterly dreadful—simply awful. But she said that every single

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day, she would have a relative or friend of one of her patients say those words: “Can’t you do something? He or she has clearly had enough. They have no dignity. This has gone too far for too long. You wouldn’t want this. This needs to end.” In passing legislation to assist those three, whose circumstances, with the best palliative care provision, were still too dreadful to continue, and have them seek an earlier death, we must be very careful to ensure that there is no pressure on the hundreds of others who are not seeking an earlier death, even though their closest relatives might be seeking an end to their real or perceived suffering.

I am eternally grateful for my family supporting my late husband through his illness and that we could afford the psychological support for Hal. He never contemplated accessing voluntary euthanasia again. All of our immediate family support network were totally focused on supporting Hal’s desire to keep fighting and beat the disease.

In closing, I would like to thank the many constituents who have contacted my office by email or phone and respectfully related their views on this issue. I can assure those both for and against that I will keep your views front of mind while we continue this debate and I determine where my vote will land.

[Applause.]

MR J.R. QUIGLEY (Butler — Attorney General) [9.57 am]: Madam Acting Speaker, I stand before you without a prepared speech. I just want to give you some of my reflections on this important legislation. When I say “without a prepared speech”, it is a subject to which I have given some years of thought, because as a practising Catholic, although a stumbling and by no means a good example of one, I am nonetheless informed by the tenets of that faith. When the party went to the election on the promise of introducing this legislation with a conscience vote, I had to start giving the matter early thought. I was conflicted during that period of time, and, might I say, I badly, but humbly, offered thoughtful prayer on this matter and where I would stand when it came before the Parliament. I do not want to keep anyone waiting: I will be voting firmly yes. It befalls me, therefore, to explain to the Parliament, and most of all to the people of Western Australia, why I will be voting yes.

This bill unfortunately has been mischaracterised by subeditors at *The West Australian*, not by the writers of *The West Australian*. I note that an article in this morning’s newspaper states that voluntary assisted dying will be available to those who will probably die, on the balance of probabilities, within six months. That is not an accurate reflection of clause 15(1)(c)(i) of the bill, which states —

is advanced, progressive and will cause death;

The first test is that that which the patient is suffering from will, not on the balance of probabilities and not even beyond reasonable doubt, but as a matter of certainty, cause death. The balance of probabilities test comes in only when “when is this death going to occur?” On the balance of probabilities, this certain death will occur within the next six months. That is a nuance, but a very important point to make by the media if they can find the time and if the subeditors can fit that into their articles.

I do not intend to now go to the provisions of the bill otherwise, because they will be debated in the consideration in detail stage. We have all been heavily lobbied in the period leading up to this debate. I want to tell members about some of the lobbying I have received as a member of a Catholic community. I went to my daughter Lily’s first Holy Communion—a significant event in the life of a young child brought up in the church. My daughter was looking angelic in her white communion gown. I had been to all of the preparatory lessons with her. All the little angels were sitting in the front three rows and the parents were in reserved seating behind those three rows. I watched with both humility and pride as my daughter Lily, who is turning 10 in two weeks—she reminds me every morning—celebrated her first Eucharist. At the end of the celebration of the Eucharist, Father Richard took the pulpit and turned to the congregation and to the little children in front of him to welcome them into a more fulsome celebration of church life. Towards the end of his homily, he said, in front of the little angels, “And we don’t want any of this euthanasia in Western Australia.” That was the first big error of his homily, because this bill is not about euthanasia. I say to Father Richard when he reads this that this is not about euthanasia or someone making a decision about whether someone else lives or dies. No, Father Richard; this is about someone who is dying and can no longer sustain the pain of what they are going through. I understand the Catholic tradition of suffering as part of growth. I understand that the crucifixion is central to the Catholic and Christian religions. However, according to the Australian Bureau of Statistics figures, we Catholics have now fallen behind those in the ABS statistics who say that they are of no religion. “No religion” now tops the pops at 31.1 per cent of the population. Catholics come in at 22.6 per cent—they are only nominal Catholics; they are not ones who are going to church every Sunday—Anglicans at 13.3 per cent and the Uniting Church at 3.7 per cent. The majority of the population as a group are those who would signify no religion.

There we are at First Communion and father says, “We don’t want any of this euthanasia.” That is a big error; it is not euthanasia, Father Richard. He then goes on and says, “So we want you to contact the politicians.” It was a full congregation because it was the celebration of the First Communion. He said, “We want you to contact the local

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politicians to tell them that we don't want euthanasia." But that was not the end of it. Father Richard then pointed me out in the third row and said, in church, "There is the Attorney General, Mr Quigley, so you can all approach him and tell him you don't want euthanasia." I had no issue with that because that was in the Catholic church that I visit voluntarily. I could not go there or I could not listen—that is my choice. He pointed me out. At the end of mass, the first communicants were having their photos taken. Anyone here who has been to one of those services would know that families have their little kids up in front of the altar. I was one of the last families to leave. I purposely positioned myself at the back of the church just inside the door. Father Richard was outside. I have never reported back to him the results of his invocation to the community to approach me and say "no". As he approached me and made this invitation in a public place, I am sure he would not think it discourteous in any way that I respond in a public place. Father, the result was that not one of your parishioners approached me—not one—to say, "Don't do it, John." Not one of them even came by, sort of embarrassed, with their thumbs down. Furthermore, my daughter attends the Catholic school up there, and we are on an email list. Not one of the parents sent me a private email saying, "Don't do it, Johnny!"—not one of them.

Following my attendance at that mass, my wife and I had arranged a dinner. I think members would know what they are like. After First Communion, there is a celebratory dinner. It was at a big Italian restaurant with a long table, with the parents drinking red wine and eating pasta and the kids running around in their little white frocks. We tried to hold them at the table but it was impossible. All the adults at the table had been parishioners at that mass. Some of them said, "That was a bit tough the father pointing you out and saying that everyone should go and see John and say no." I said that I went there as a voluntarily person. In a democracy, why would I take offence at that? However, each of the adults at that table who were in that congregation said, "John, if there are enough safeguards, you must support that legislation. You must give the population the option." They were all the people there who heard the sermon. They were all the people who were asked to come and tell me no.

I say this: I would disagree with the Premier on one small point, but this is a conscience vote so I am allowed to disagree with the Premier on one small point. As a Christian, if I enter a room and there is a poor person dying in pain on the bed and the person is one of the 30.1 per cent of the population who thinks that everything I believe in is hocus-pocus and a myth, a fairytale written centuries ago, and says, "John, can you pass me that glass there because I want to drink that potion", this is where I disagree with the Premier. We are not looking death in the face here; we are looking at dying humanity in the face here. I am not looking at a dead man, Premier; I am looking at a living man who does not believe in God, Christianity or a life after, but who turns to me, a Christian, and says, "John, can you pass me that cup to drink from?" How can I, in charity, deny a non-believer and say, because of the tenets of my belief, "Suffer on, baby; suffer on"? That is not a Christian attitude.

I reflected on and was moved by the Leader of the Opposition's speech and the journey that her late beloved husband, Hal, went upon—a journey that he chose to go upon, that may have had something to do with St John of God on Scarborough Beach Road. It may have had something to do with Catholicism. It may have had something to do with all of that, and will inevitably have something to do with the decisions I make when my time comes. But that is voluntary. I do not have to visit my views on someone who thinks that I am stupid and that I am a grown man believing in myths. I cannot force that on someone who does not believe because that is in my mind unchristian. I remind the Parliament—I do not want to be here as a bible basher—that when God sent his only son to earth, he did not send him to Rome to heavy the senators to change the laws to stop mass execution by crucifixion or to free the slaves. He just sent him to live amongst the poor to live a life of perfect love and charity and to set for all an example. He did not put upon religion to change the laws of earth. Indeed, it was Saint Augustine of Hippo, one of the great saints of Christianity, who first wrote in the late fourth and early fifth centuries of the separation of the law of state and the law of heaven, and how we on earth cannot write laws for heaven. On earth we can write laws that we can try to create that will allow for an orderly, civil, peaceful and loving community. I am sure that everyone here aims for that—a quiet, peaceful, gentle and loving community.

[Member's time extended.]

Mr J.R. QUIGLEY: When I was listening to the honourable Leader of the Opposition, I was reminded of the words of Dylan Thomas in his famous poem, *Do not go gentle into that good night* in which the protagonist is leaning over his father urging him to rage, rage against the fading of the light because that is what we humans want to do; we want to rage against the fading of the light. I have witnessed that firsthand. I had cancer. I had T-cell lymphoma, which is what the former head of the Cancer Council died from. I am sorry, Premier —

Mr M. McGowan: Clive Deverall.

Mr J.R. QUIGLEY: Yes, Clive Deverall. I had the same diagnosis. I attended every week for 15 months at the Peter MacCallum Cancer Centre in the long chemo room where the pervading noise was bip-bip-bip of the 30 or 40 chemo pumps going off. I took my position on a weekly basis with the same people. I saw people ailing and ailing but still getting the shunt—still getting hooked up because they were raging against the fading of the light. But there comes a point at which they do not give up, but at which the pain overwhelms the rage. Every time the

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light goes on, they are living in pain. It is only when they are unconscious that they get relief. I have witnessed it. What would I say to a person who had a potion on the bedside, “John, could you pass me that cup?” As a Christian could I say, “No, I will not.” That seems to me, after a lot of prayerful contemplation, against every tenet that I want to live by. It was Saint Paul who wrote that the gospel was written not just for Christians; it was written for everybody—but not everybody has to believe it, not everybody has to embrace it and not everybody, thankfully, has to fall off their donkey on the way to Damascus. Not everyone has to believe it. Those who do believe it take a burden upon themselves to try and live it. I fail on a daily basis; I am sorry. What my colleague the member for Scarborough described is her beloved late husband choosing an option—surrounded by family and supported. There are some who are not in that situation. There are some whose disease is different, whose pain is so excruciating, as described by the honourable Premier yesterday, that they want to choose another option. Who am I to stand here in the Parliament of Western Australia and say, “You can’t have that option because of what I personally believe”?

Out in Butler, I gave them a veritable flogging with an 18.5 per cent swing. I got the 18.5 per cent swing on about four tenets—the dualling of Marmion Avenue, building the railway, saving Western Power and getting on with the freeway. That is what the people are concerned about. But whenever I have contact with them over this issue, I get only one response: “Do it, so long as there are enough safeguards. If I get a terrible disease and I am in excruciating pain, I want to know that the option is there for me. I might not want to use it, but I want to know that the option is there for me.” Nearly everyone in the community thinks that. What I am saying is that I got elected on secular temporal issues—on what the community wants for their families. I did not come here to say, “Vote Johnny I and I will stuff the Catholic catechism down your throat.” I would not do that to anyone. I did not do it because most of them would vomit. I do not make light of it. I embrace it myself. I am talking to the 30.1 per cent of our community who do not believe in God. How is it that I could come here as a legislator and say, “Because of my own personal beliefs, you’re going to suffer. Because of my personal beliefs, you’re not going to have an option. Because of my personal beliefs”—not, Premier, when I am looking death in the face, “He’s gone”, “She’s gone”—“when I look at a dying person in excruciating pain who says, ‘Can you pass me the challis to sip from?’, I say, ‘No way. Suffer on, baby.’” I cannot do it.

I will be voting most firmly in favour of the voluntary assisted dying legislation because it contains 102 safeguards and that is what my community wants. Thank you, Mr Speaker.

[Applause.]

MR D.T. REDMAN (Warren–Blackwood) [10.17 am]: The Voluntary Assisted Dying Bill 2019 is one of the most challenging bills that any of us have had to deal with. Certainly, it is the most challenging bill that I have had to deal with in my 14 years in this place. It is certainly something that I do not take lightly. Before I embark on my conversation, the approach that everyone in this place has taken so far in their discussion on this issue has been fantastic. I am not sure that it will necessarily play out the same way in the other place, but certainly in the chamber that I am part of, it is great to hear the approach everyone is taking.

From the outset, I support voluntary assisted dying. I have held that view for some time. The only qualifications I put on this discussion is that we go through the consideration in detail process with the bill in front of us. Although I had a number of briefings on the bill, I certainly have not had, as a regional MP, the comprehensive level of briefings that I would have liked simply because I was not able to get to Perth. I want the benefit of others who ask questions about various aspects to ensure that all those things that have been talked about—the 102 protections that the member for Butler referred to—are real, valid and robust to the issues that they are meant to protect. That is my only qualification. This is going to be a very emotional debate, no doubt. I thought it important as a member of Parliament to outline the broad approach that I took to make my decision, as many others have done. In the past I have used the words “voluntary euthanasia”. I found it interesting that the member for Butler said that this is not euthanasia, this is voluntary assisted dying—a different thing. Some of my research included asking: What is euthanasia? What is the right terminology? I refer to page 3 of an issues paper from May 2016 titled “Euthanasia, Human Rights and the Law”, by the Australian Human Rights Commission. Under the heading “Terminology” it states —

‘Euthanasia’ is often incorrectly characterised as representing one particular kind of practice. However, it is more accurately understood as an umbrella term which covers a vast array of practices that can be described as different forms of euthanasia. These include:

- *Passive voluntary euthanasia*—when medical treatment is withdrawn or withheld from a patient, at the patient’s request, in order to end the patient’s life;
- *Active voluntary euthanasia*—when medical intervention takes place, at the patient’s request, in order to end the patient’s life;
- *Passive involuntary euthanasia*—when medical treatment is withdrawn or withheld from a patient, not at the request of the patient, in order to end the patient’s life;

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- *Active involuntary euthanasia*—when medical intervention takes place, not at the patient's request, in order to end the patient's life.

Of course, voluntary assisted dying fits most accurately into “active voluntary euthanasia”. I say that because on page 35 of the same document reference is made to the complexity of the decisions around this. The word “euthanasia” is used. I have referenced how that is defined and I think members will understand why I am reading it. The final commentary in the document states —

Individual support for the issue of euthanasia is, at its core, a matter of personal belief. Values based on ‘sanctity of life’ and ‘personal autonomy’ are usually grounded in deeply held moral and/or religious beliefs. Further, supporting euthanasia may not be an absolute position. People may support some forms of euthanasia, such as passive voluntary euthanasia, —

That is the dominant bit that we are talking about here —

while rejecting other, more active, forms of euthanasia.

I think that that is a really important comment to make in this debate at this time.

The other question that hit me was: why take the path of legislation? These things are happening and we could simply decriminalise it. However, I think it is important to ensure that we get past, if you like, the decision for why legislation was considered to be important in taking these proactive steps. I will quote from page 37 of the same document. The comment there is broadly about some of the slippery slope arguments that if we start down this path, we will get into a very difficult situation and it will then go beyond where the community wants to go. But members will understand why I am referring to this quote. It states —

‘Slippery slope’ arguments are primarily concerned with the risk that unsanctioned deaths would occur without specific consent and/or in non-terminal cases. The practical solution to this would be to improve the safeguards contained within any regulatory regime in order to prevent this from occurring, to the greatest extent possible.

Well drafted ‘proactive’ legislation permitting and regulating active voluntary euthanasia can deliver certainty, transparency and above all, protection to all who may be involved in these practices.

Indeed, at page 225 of the Joint Select Committee on End of Life Choices report—I compliment all parties who were involved in this inquiry; the report is a fantastic piece of work—one recommendation comes to the point I am making. In the little box headed “Voluntary assisted dying legislation framework” it states —

Rather, the legislation should reform the law with a standalone Act that permits voluntary assisted dying to eligible people in accordance with strict criteria.

I think that having very proactive legislation that puts in place a clear set of boundaries is really important as the starting point in this discussion.

How did I come to my decision? How did I come to my broad position of supporting the legislation, with the only qualifier that a bit of work needs to be done in consideration in detail? Firstly, the polling has been massively compelling. If we do not have an eye for our electorates and for the view of people, we are really missing the point about why we are here. I thought the best articulation of that was from the member for Dawesville who, I admit, did considerably more work to engage with his community than probably anyone else in this house. The position that came back was very, very compelling, and it is certainly the view that came through in the strongest sense in my electorate. In *The West Australian* earlier this week we saw the headline “88%”—targeted. That is a really compelling position. As the member for Dawesville said, there does not seem to be a quiet vote sitting out there that is waiting to come forward. I think the polling is extremely compelling and is certainly something that is also reflected in the “My Life, My Choice” report.

Our own experiences are, I guess, the most difficult part. I congratulate the Leader of the Opposition for her commentary. It is very difficult to stand up in this place and put a personal experience on the table, because it is close; it is family and we do not particularly like putting that out on the table. As members know, I had a bit of an emotional experience before we went into the winter break—I am talking about my brother, who had mesothelioma. That is probably the most stark example for me. Probably not many people in here have not had the same experience, and I acknowledge that others are in the same situation as I am. My recollection from my conversations with my brother over the last six months of his life was that he would have absolutely wanted to have had the choice of a voluntary assisted dying end-of-life pathway. Yesterday, knowing that my speech was coming on today, I took the time to ring my sister-in-law to confirm that those were his views. She said, “Absolutely; yes. When he was diagnosed and still well, that was his view. That did not change right throughout the process”, which only took about six months. He is one very close member of my family who would have liked to have had that choice. It is pretty hard to be a judge from a distance, but I am pretty certain that in his situation, he probably

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would have taken it up given the nature of the disease that he had. But, again, none of us knows that until we get to that point.

I only really knew three of my grandparents—one died when I was a year old. At least one grandparent clearly articulated to me before she died that she would have wanted some sort of support for what she described as voluntary euthanasia, and that a voluntary assisted dying option would have been something that she would have liked to have been a part of. She was one step short of pleading, but she certainly put a very strong view to me. My father-in-law passed away from lung cancer. He was a smoker. His death occurred in my in-laws' home; he spent his last hours there, and it was not something you like to watch. Our kids were around because there was a view that it was a family affair, and it was very, very confronting. He was in a hell of a lot of pain in those last stages, despite all the support from palliative care staff—Silver Chain, I think—who, at the time, were not able to deal with that. Nevertheless, he had a strong Catholic background and it may not have been an option or choice for him. However, after seeing that, I understand why legislators want to give people the option.

What is also really important in this debate is knowing the views of those groups of people who have been affected by pain and the indignity of dealing with that pain. A lot of articles and books have been written about this issue and those examples will be reflected upon in here, as they will in the other house. They are extremely compelling. As the member for Butler said, people must have choice. I think that is really important. It does not mean that people will choose that path—many will not, for a range of reasons. Many will simply like to have the choice but may not choose it, but others may choose it as their path. I think that choice for those eligible participants is a really important part of this legislation.

The other choice that has not been mentioned much is the choice of health practitioners to not participate—conscientious objection. That is a really important piece to this as well. None of us wants to put a health practitioner in the situation of doing something that is against their personal views and beliefs. I think that that other choice—part of this bill—is really important. Another factor to consider is palliative care, which is massively important in regional Western Australia. Recommendation 13 on page 83 of the report refers to the importance of delivering palliative care, particularly in regional Western Australia and some of the more remote parts of WA. There are difficulties and challenges with that, but ensuring palliative care is critically important. There will probably never be enough dollars for palliative care. Part of the Nationals WA's politics is to try to get some equity for those people who live in parts of the state that are far from the key services that the state delivers. There probably will never be enough dollars for that. If we prosecute the argument that we want a voluntary assisted dying pathway with access to doctors and medical practitioners who can deliver on that, should they choose, that is also an issue. Both palliative care and support for voluntary assisted dying, should they choose, will be resource issues in regional Western Australia. For that reason, I am not linking the two as strongly as perhaps others are. My support for voluntary assisted dying in this legislation is not premised on top-quality palliative care services in every part of the state. That cannot be done, because there will always be resource issues in regional parts of the state. Likewise, there will also be resource issues in delivering the availability of doctors for people to pursue taking part in a voluntary assisted dying pathway.

I do not support what one other particular minority political party has said—that is, the trade-off of not supporting the bill unless we have a certain level of palliative care. I do not support that. This bill needs to be debated in its own discrete way and the issues should be addressed as they come up. Palliative care is massively important and I do not underrate it but I am not linking resourcing regional Western Australia to my support for the bill. It is massively important that the government does whatever it can do—no doubt the National Party will continue to prosecute this—to put resources into services in regional Western Australia, isolated parts of the state and remote communities.

Also of critical importance is the level of support and commentary on not being able to palliate, if that is the right word, those people who are in unbearable pain. Finding 23 on page 107 refers to the fact that not all suffering can be palliated. Page 11 of the Australian Human Rights Commission article that I quoted refers to the same issue. It states —

For example, the South Australian Voluntary Euthanasia Society explained:

It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients—between 5–10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.

That is a really important point. Likewise, the minister said in his second reading speech —

Equally, when members of the Australian Medical Association were surveyed on this issue in 2016, 67.9 per cent of respondents agreed that there are patients for whom palliative care or other end-of-life-care services cannot adequately alleviate their suffering.

A group out there will suffer irrespective of the best services we can provide for them.

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[Member's time extended.]

Mr D.T. REDMAN: The report refers to advance healthcare planning, advance healthcare plans, advance health directives and enduring powers of guardianship as strategies that are in place now and refers to the roles that they play. Clearly, they are not suitable substitutes for the bill here. They have a range of benefits, but they also have some flaws, particularly advance health directives, for which there is a very clear demonstration of a low uptake. I think page 41 of the report highlights the low uptake. A huge issue is the failure of some doctors to honour advance health directives. As legislators, it is important that we cast our minds to all those things that are in place and how well they deal with the issues that we are highlighting here that are key to this legislation. I am convinced that there is nothing suitable to replace this as a path, and that reinforces the importance of legislating for voluntary assisted dying. I found it an interesting read.

Page 109 of the report refers to lawful options at end of life. If someone had asked me the question, I would have come up with a couple, but there are a few more there. I did not consider suicide as being a lawful option but it is not against the law.

Mr R.H. Cook: It's pretty hard to prosecute after the event.

Mr D.T. REDMAN: Absolutely. The lawful options highlighted include a refusal to take medical treatment. Depending on the circumstances, it might take a certain time before someone dies as a product of that, but I am very, very confronted by the consequence of refusal to take food and fluids. Someone who has no legislative choices, without breaking the law can choose not to eat or drink and, therefore, simply deteriorate over a time. That is terribly, terribly confronting. We have read and heard of examples of people in our community who have chosen that path. I cannot imagine how terrifying it would be to do that, let alone be a family member or friend watching that occur before my eyes. It is just a terrible situation. Terminal sedation is very, very legally challenging. I have no doubt—in fact, I know, but I am not going to put it on the record here—that a level of sedation has been given under the banner of palliative care. It is done simply to have someone drift off to sleep, which is the outcome that probably everyone sitting around the patient, and the patient, would like to see. That activity happens, but we owe it to our medical fraternity to give a level of protection in these situations by defining those issues. This would give a choice to someone who chooses to take that path and take it out of the somewhat legally limiting path of terminal sedation.

I was intrigued about the report referring to suicide as a lawful option. Page 140 of the report mentions that some 10 per cent of suicides are by people who have chronic illnesses and hence choose to suicide. That really concerns me. In more rural parts of Western Australia, people are massively pragmatic. A lot of them have access to firearms and a very pragmatic approach is taken to managing animals in distress. Their mindset is perhaps quite different from someone who might not have access to options, if you like, to choose a suicide path. I do not like that. I do not like those choices being the only ones that people have. I think that adds to a compelling argument. Page 148 of the report refers to the range of issues that emerge under this heading of lawful paths that are available now and their limitations. If members have not read the four dot points on page 148, I advise them that they are certainly worth a read. It refers to the shortcomings of those choices.

We do not stand here paving a new path. We stand here making legislation on the back of the experience of other jurisdictions around the world and, in the short term at least, the experience of another jurisdiction in Australia. That is a massive benefit because significant arguments will be put up as challenges in this discussion and we can go to the national experience to give us some guidance on the outcomes. We will have arguments about the slippery slope, the safeguards not working and the abuse of the vulnerable. The latter was one of my big concerns. Aged care in regional Western Australia is an emerging challenge. We do not want vulnerable people to be coerced into a situation that they do not want to be in. It is similar for the arguments to prevent suicide. I am comfortable with my reading of the examples in other jurisdictions and the commentary on page 181 where the committee concludes that the risks can be guarded against. There is sufficient evidence—not only a comment by a minister—to suggest that the risks can be guarded against. I do not think that any jurisdictions with voluntary assisted dying legislation, just about without exception, have made subsequent changes to fix anything. I think that sends a very strong signal. That said, if we get through all of this and to the point of supporting this pathway, we will have to put it down in black and white, and that will be the hardest bit. Writing down all the rules, risks and responses will be the hard bit. Hence, I think the consideration in detail stage will be a really important part of this discussion. I will go into that debate in the position of being well-read and well-versed on this topic and how it works, yet this is one of the qualifiers as we work through that. In every likelihood, I will support the bill, but I want to ask a number of questions and listen to other commentary about this legislation.

There are eligibility criteria. There is a whole process for VAD, with an assessment process involving three requests, independent witnesses and two doctors. There are checks and balances and a range of important processes—102, in fact—that reinforce and are wrapped around a very, very robust piece of legislation to manage the complexity and

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the range of issues that could emerge from a bill that will have such far-reaching consequences as this bill. I believe the bill, as I read it now, does that, but, again, the consideration in detail stage will be very important.

There is a predominant expectation in the community that both houses will support this bill. The community expects that and this is what it wants. I think it is incumbent upon us to deliver on that. I recognise there are strong views on this issue. I absolutely respect the views others have expressed. I expect many will think that this legislation does not go far enough. Someone asked me—this is relevant to the comments the Attorney General made yesterday—if they had an advanced health directive, could they access voluntary assisted dying to ensure that if they developed dementia, they could take action to get on the pathway to voluntary assisted dying. The answer is no, because there is an enduring view that people need to have capacity at all points in time to make a valid decision. I think the Attorney General yesterday dismissed that. He said that this is not a path the government is going down. Certainly, those were the comments of a couple of constituents who have approached me. I think the view of some is that we are not going far enough on this; others will think we can never put enough rules in a bill to deal with all the issues.

I am very pleased that we are taking a very cautious approach, given we are introducing legislation that is controversial, very emotional and very personal, but nevertheless something that people want. If we overreach with this legislation, it will be off the table for a long, long time. People will hold the view that we have not gone far enough, but I think we have pitched the politics right, and I pay tribute to the minister for doing that. It is important for the government to understand the politics and the reach of this legislation to get the support of both houses so the legislation can get through and be put in place. I think that cautious approach is absolutely right.

In closing, the price of getting this legislation wrong is high. It is incumbent upon all of us as legislators to navigate all the issues and to quiz the government and the experts on the various aspects of the bill to ensure that we absolutely understand what the clauses mean, so that when it is passed in this house—I am pretty certain it will come back from the Legislative Council—and gets royal assent, it will be the best that these two houses can do for something that the Western Australian community wants.

MS M.M. QUIRK (Girrawheen) [10.43 am]: We all approach the very important Voluntary Assisted Dying Bill 2019 through the lens of personal experience. In this context, I want to particularly make mention of the Leader of the Opposition for sharing what was a very tough account of her personal experience. Throughout this debate, we have heard and are likely to hear harrowing and emotional accounts from members. No experience is any less legitimate than another.

Mr Acting Speaker, I am being distracted by a conversation in front of me.

The ACTING SPEAKER: Attorney General and Minister for Health, I am afraid you are distracting your member.

Ms M.M. QUIRK: My views are formed from a complex amalgam of factors. Yes, I am an imperfect Catholic and I firmly believe life is valuable but other influences were operative in my approach to the bill. It would be trite to attribute the issues raised by me as being a slavish adherence to Rome. I acknowledge that we live in a pluralistic society and enunciating my views is not an attempt to proselytize those who have differing views. Characterising arguments in this way shows a lack of appreciation of how complex and multifaceted issues such as this can be.

My experience includes time served on the Sir Charles Gairdner Hospital board, co-chair of Parliamentary Friends of Palliative Care for the past two years, work as a former volunteer with Alzheimer's WA, a background as a prosecutor and administrative lawyer and someone who has personally experienced clinical depression. I also had the great privilege of being Minister for Disability Services; Citizenship and Multicultural Interests; Seniors and Volunteering. In opposition, I was shadow Minister for Seniors and Ageing and grappled with serious policy issues such as elder abuse. As Chair of the Community Development and Justice Standing Committee, we undertook a significant inquiry into policy issues for government in an ageing population. I regularly visit an aged-care facility and I have been at the bedside of close relatives who have died.

As the member for Girrawheen, over the years, in response to constituents' concerns, I have engaged in an ongoing dialogue with hospital authorities and successive governments for improved palliative care in the northern suburbs. Importantly, the views of constituents who have written to or contacted me about this bill are significant. Finally, representing a multicultural electorate, the cultural considerations and implications of such laws need greater attention.

I acknowledge that I will be mindful of subjective influences such as those I have outlined in exercising a conscience vote. But, members, I cannot stress enough that we also need to dispassionately and objectively consider the individual clauses to assess how these laws will operate in practice, whether there will be any unintended consequences, whether the most vulnerable will be adequately protected and whether these laws will profoundly corrupt the practice of medicine. I also reject outright the assertion that anyone who departs from the orthodoxy lacks compassion. No-one has a monopoly on empathy, and heartfelt emotions are sincerely felt on both sides.

At the outset, before I focus on a number of specific concerns, there is a need to clarify some of the words and terms used in public discourse on these proposals over recent months. There is a level of ambiguity in terms used,

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which obscure meaning. Some of the words used are capable of having different interpretations and others have an ordinary meaning but have been framed in such a way as to be misleading. For example, we were told in the minister's second reading speech —

I would like to emphasise that this bill has nothing to do with euthanasia. This is about providing assistance to someone who is already dying. It is not euthanasia and it is not suicide.

This begs the question: why is it not euthanasia; and, if it is not euthanasia, what is it? I am not being quarrelsome or pedantic; this is a legitimate question. Given that this is the term used in the media, on talkback radio and in water-cooler conversation, it is important that we understand what is it we are doing with this legislation. It is true that the term is ambiguous. The distinguished chair of the expert panel, Malcolm McCusker, AC, QC, told a consultation session that I attended that the word had not been used in the panel discussions or report because it carried negative connotations.

The term “euthanasia” derives from ancient Greek language—I might require the member for Hillarys to correct my pronunciation—“eu” meaning good or noble and “thanatos” for death, giving a literal meaning of “good or happy death”. Used in that sense, I am sure we would all agree that one hopes that everyone is in favour of euthanasia. One of the active groups advocating for these laws calls itself “Go Gently”, which, of course is a direct reflection on the very origins of the term. But I can see that the original meaning has evolved, and there is confusion in that it now means “terminating life intentionally”. In these circumstances, I can understand why it was considered wiser to eschew the term. However, if an opinion poll asks people whether they support euthanasia and the pollster understands the word to mean “giving patients a lethal injection”, some people polled may think it means something altogether different, such as a patient asking for life-prolonging treatment to be withdrawn because it is too burdensome. Then, the results of the poll would be worthless. Those who assert justification for this legislation do so on the basis that there is a grey area for doctors when treating terminal patients, leaving the medical profession in legal jeopardy. Such proponents fail to understand that in criminal law, the intention to kill is routinely inferred from objective circumstances.

Much has been made of the extensive consultation on this bill. A person would be seriously mistaken to think that the word “consultation” is given its ordinary meaning of discussion, dialogue, debate or seeking advice. Anyone who attended these fora will know that comment was not invited nor wanted from those opposed to this bill; the introduction and enactment of the legislation was presented to the audience as a *fait accompli*. Rather, it was to seek feedback on how the law should operate. Those who were interested in the topic did not have access to a draft bill during those consultations.

It could be said that people opposed to the issue in principle had the opportunity to make submissions to the Joint Select Committee on End of Life Choices, and they did so in volumes. There were hundreds of written submissions from people who are concerned about aspects of the proposals or the legislation for a variety of reasons. Sadly, few of those submissions were given any weight or addressed in the majority report. There were other sections of the community who simply did not participate in the debate whatsoever. The figures and analysis of the demographics of the participants in the appendices to the expert panel's final report are enlightening. A bit more of that later.

The response by proponents to this would be to say, “Well, people have the choice whether to participate in consultations or similarly to avail themselves of an early death.” Again, this language is opaque, because so-called choice is illusory, especially in regional and remote Western Australia, where timely access to palliative care is largely unavailable. There is also the widely asserted premise that pain management cannot be accomplished in the majority of cases. This does not coincide with current medical experience.

The reasons patients gave when requesting physician assisted suicide in Oregon have been consistent for the last 20 years. Of those patients, 90 per cent reported a decreasing ability to participate in activities that made life enjoyable, 90 per cent reported a loss of autonomy, and 65 per cent reported a loss of dignity. Each of these patients were asked to rate the importance of 29 factors in influencing their request for aided dying. The highest-ranked reasons were wanting to control the circumstances of their death, concerns about future quality of life, concerns about future pain, concerns about the future ability to care for oneself, a loss of independence and a desire to die at home. Among the lowest-rated reasons for requesting assistance were depression, lack of support, financial concerns, current pain and quality of life.

Finally on the language used to frame this debate is the word “safeguard”. A safeguard is a measure taken to protect someone or something or to prevent something undesirable. Many of the so-called 102 safeguards are really eligibility criteria rather than protections. It is worth noting that there are fewer protections than in Victorian law. Surely, Western Australians deserve the same level of protection.

Former Prime Minister Paul Keating referred to safeguards in the context of the Victorian legislation in an opinion piece in the *Sydney Morning Herald* in October 2017. He stated —

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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. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system.

I have limited time to address all of the substantive issues that we need to satisfy ourselves about in the proposed regime; I anticipate these will be canvassed during the debate at the consideration in detail stage. These issues include: What is a level of testing for capacity of an individual to make such a momentous decision? How can we be satisfied that a decision by a patient is not largely the result of undiagnosed depression or mental illness which could be medically addressed? How is the possibility of coercion tested? Should certain individuals be referred for an expert psychiatric assessment as a matter of course? Is the measure effectively a default position because adequate or timely palliative care is not accessible? Should there be a notation on the death certificate or should the coroner be notified?

People have asked me why Western Australia did not just copy the laws passed in Victoria. The Minister for Health explained this very well in his second reading speech, as follows —

The Victorian legislation presented Western Australia with the opportunity to examine the approach taken in Victoria. However, during the development of the bill, the circumstances and needs of Western Australia have been kept in mind. Western Australia has different clinical models than Victoria due to its geographical size and location. WA is the most culturally diverse state in Australia, with Aboriginal people, migrants and refugees accounting for nearly 30 per cent of its population. Where possible, consistency with the Victorian legislation has been maintained; however, this bill reflects what is suitable for the needs of Western Australians.

The underlying issues to which the minister alludes is that unlike Victoria, there are many remote areas that are not currently serviced by adequate or any palliative care. With a larger First Nation population, more attention needs to be given to cultural distinctions like the need to die on country and the lack of trust in mainstream health services. The final report of the expert panel canvasses these issues well, but it serves to reinforce in my mind the imperative to hasten slowly.

Senator Pat Dodson made a powerful speech in the Senate on the Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015, a private members' bill, in August of 2018. In it, he addressed the challenges of euthanasia for First Nation communities —

“Any proposed legislation to change assisted suicide legislation must occur in consultation with First Nations health services and communities. It is the First Nations people who are at higher risk of being in a situation where assisted dying may take place.”

Under the United Nations Declaration on the Rights of Indigenous Peoples, article 24.2 states —

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

We know that Australia's attempt to achieve the realisation of that right through the Closing the Gap program has been an abysmal failure. First Nation people do not enjoy the same quality of life in this country at every stage of their existence, as shown in the national figures. In the womb, a First Nation child is at higher risk of contracting life-threatening bloodborne diseases. Last year, six First Nation babies died of syphilis. Children are more likely to be diagnosed with chronic health conditions such as type 2 diabetes. They are at greater risk of contracting meningococcal and rheumatic heart disease. As teenagers, they watch their friends, cousins and siblings prematurely end their own lives. These facts are true of the Northern Territory and nationally. In the Kimberley region, where I come from, the suicide rate is the highest in the world. By what most Australians call middle age, many First Nation people are already living with kidney failure without sufficient access to dialysis. The burden of disease and disability in First Nation communities is far higher than it is in the general population. First Nation people are more likely to live with a severe or profound disability and to die younger. On a national basis, First Nation men can expect to live to an average age of 69, while non-First Nation men can expect to live to an average age of 80. First Nation women can expect to live an average age of 73, while non-First Nation women can expect to live to an average age of 83. All governments—state, territory and federal—have failed to enact the necessary action to close the gap.

[Member's time extended.]

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Ms M.M. QUIRK: We have failed to address the health issues suffered by First Nation people to date. With so many of our people suffering complex health conditions at an earlier age, there is a desperate need for culturally appropriate palliative care services in regional and remote areas. A review recently commissioned by the Australian government confirmed that more needs to be done to ensure First Nation people receive palliative care within their community. It states —

“Where First Nations people are already overrepresented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death.”

Paving the way for euthanasia and assisted suicide leaves First Nation people even more vulnerable when our focus should be on working collectively to create laws that help to prolong life and restore the right to enjoy a healthy life. The only concessions I can see to these challenges for First Nation people in remote WA is the ability to use a nurse practitioner to deliver the lethal dose, the use of interpreters, if necessary, and the need to significantly expand culturally appropriate delivery of palliative care.

This brings me to the issues around culturally and linguistically diverse Western Australians. I will make the following observations. Despite consideration of the issues for CALD communities and appropriate representation on the panel, there was little participation by CALD communities in the consultation process or in making submissions, and minimal use of the expert panel’s online vehicle, Citizen Space. A stakeholder meeting with the panel was convened at which only seven people attended. The panel found that awareness-raising would be required for CALD communities and that interpreters who were not family members and had the necessary accreditation would be needed to navigate a patient through the process. I am certainly mindful that for the elderly for whom English is not the first language, there is the tendency to revert to their first language. On complex matters such as exercising a choice between life, ostensible familiarity with English should be treated with extreme caution. The lack of participation of CALD Western Australians in discussions on voluntary assisted dying may evidence either a lack of demand or interest in pursuing this course of action.

Access to palliative care is an issue in not only remote and regional WA, but also the northern suburbs, directly impacting on my electorate. What is optimal palliative care and what is meant by palliative care is not well known within the community. Many consider it to mean solely the last few days of life, a time when many feel trapped in a technologically sophisticated, seemingly uncaring world of medicine. At such a late stage, there is not the same opportunity to markedly improve quality of life as there is if palliative care is engaged immediately upon diagnosis. Palliative care helps people to live their life as fully and as comfortably as possible when living with a life-limiting terminal illness. Palliative care identifies and treats symptoms that may be physical, emotional, spiritual or social. It is essential that options for palliative care be explored at the time of terminal diagnosis. It is about ensuring quality of life in the time remaining. It is about living well with a terminal illness. Sometimes palliative care can be of benefit to a person at their initial diagnosis or useful on and off through various stages of an illness. Many people have long-term interactions with their palliative care team, seeing them during the course of their illness. There are many elements to good palliative care including pain and symptom management, and advice and support to carers. Palliative care ensures patients are kept comfortable and can, as I said, maintain a good quality of life. Ideally, it involves many health professional who can all bring a range of skills to manage illness. These professions include doctors, nurses, social workers, physiotherapists, occupational and speech therapists, psychologists and trained volunteers.

In the context of my constituents, the Joint Select Committee on End of Life Choices found, at page 67 of its report under finding 10 —

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

Following that finding, it made the recommendation —

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

Surprisingly some members might know that an area built especially as a hospice at Joondalup Health Campus already exists, but it is not currently being used for that purpose. If the other planned extensions can be expedited, patient capacity for palliative care can readily be accommodated at Joondalup.

I welcomed in May the additional funding for palliative care in the 2019–20 budget. I have a table which shows the breakdown of the \$41 million allocated in the budget. In accordance with standing order 86, I seek leave to have it incorporated into *Hansard*.

Leave granted.

The following material was incorporated —

Extract from Hansard
[ASSEMBLY — Thursday, 29 August 2019]
p6088b-6116a

Mrs Liza Harvey; Mr John Quigley; Mr Terry Redman; Ms Margaret Quirk; Ms Emily Hamilton; Mr Peter Rundle; Mrs Lisa O'Malley; Amber-Jade Sanderson; Ms Libby Mettam; Dr Tony Buti

	2018–19 \$'000	2019–20 \$'000	2020–21 \$'000	2020–22 \$'000	2020–23 \$'000	Total \$'000
Regional Palliative Care Services		5,081	6,482	8,015	10,586	30,164
End of Life Choices — Project Funding	1,741	2,279	1,795			5,815
VAD Recommendations	1,006	1,488	1,065			3,560
Palliative Care and End of Life Choices	735	791	729			2,255
Capital — Carnarvon		4500	500			5,000
TOTAL PACKAGE	1,741	11,860	8,777	8,015	10,586	40,979

Ms M.M. QUIRK: This additional \$41 million over four years includes \$5 million previously planned for aged care in Carnarvon that has now been rebadged as an aged-care and palliative care facility, and \$5.7 million for implementing the voluntary assisted dying regime. That is a start, but it is still inadequate. Most of the money has been allocated to regional palliative care, which is sorely needed if we are to provide any access at all in the remote regions of WA. As an aside, I am indebted to the minister's office, and in particular Marion Huntly, who provided me with these figures and also responded to a range of other queries I had.

It is calculated that the appropriate ratio for palliative care specialists in Western Australia should be two specialists for every 100 000 people. WA currently has 0.57 specialists for every 100 000 people. It is estimated that over the next four years \$600 million will be needed, and medical specialists in the field need to increase from 15 to 50.

Despite the ageing population, it is trite to say that the elderly can suffer social isolation and feel as though they have outlived their usefulness and are a burden on not only their family but also the health system and the community generally. We also know that the incidence of elder abuse is significantly under-reported, with victims ashamed to report it because perpetrators are often family members. I am strongly of the view that these laws will be seen as a way out for those poor souls who feel that they have outlived their usefulness, have had a full and satisfying life and do not want to become an unproductive burden. This throws some of the bill's safeguards into stark relief. How thoroughly will possible coercion be investigated or considered? This is yet another matter that will be explored in consideration in detail. Senior Western Australians deserve our respect and to be valued. Laws such as this one send the wrong signal to them. For the elderly, feelings of guilt and redundancy may well outweigh the choice that is said to operate under this bill. In the words of former Prime Minister Paul Keating, yet again —

Once this bill is passed —

That is the Victorian legislation —

the expectations of patients and families will change. 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. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.

The passing of this bill is akin to unfurling a white flag of surrender. In waving that white flag, we are conceding that we cannot marshal the considerable resources in our health system to allow those with a terminal illness to enjoy a quality of life in their remaining time. We are conceding that in a state like WA, we cannot provide timely access to palliative to all Western Australians irrespective of where they live. By giving up, we consign the vulnerable, depressed, mentally ill and socially isolated to the risk of coercion or, worse still, that they have no choice but to accede to an early and untimely death. We are ultimately choosing between two systems in which some suffering may be difficult to treat or manage and one in which regulation is very difficult to perfectly enforce.

The final words of Paul Keating are very apt considering the remark of the Attorney General. Paul Keating said —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

MS E. HAMILTON (Joondalup) [11.11 am]: I rise to make a contribution to the Voluntary Assisted Dying Bill 2019. Let me start by saying that it takes a bold government to deal with a complex issue like the one before the house at this moment—yet here we are doing what is right. To say that there are mixed views on this piece of

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legislation would be an understatement, and not to recognise that people have strongly held views would be to not understand the issue. Each of us has a personal story, a point of reference for this debate, and we need to ensure that when we talk about this issue, we listen to each other and have a respectful conversation.

What we have before us today—what we, as legislators in this house have been asked to do—is to represent our community's views on the Voluntary Assisted Dying Bill that the McGowan government has introduced. We are dealing with a conversation that is long overdue and that our community is telling us they want to have—providing those individuals, who are suffering as part of an advanced progressive terminal condition, with an additional choice, which will provide compassion and dignity at the end of one's life. We know there is 88 per cent community support statewide. This is reflected in Joondalup with over 80 per cent support, which is why I will be voting in favour of voluntary assisted dying.

As a decision-maker, politician, parliamentarian, community leader, or whatever way you want to look at it, each of us have a conscious vote in this place on this bill. To be able to speak to this legislation and represent the views of my Joondalup electorate is a privilege. It is the case that we have so many choices in life. It is one of the benefits of the society that we live in. But as a society, we do not engage in the conversations around death and about what we would like to happen when it is our time to leave this earth. We do not talk about the choices at the time of death very openly; it is just not something that we spend a lot of time discussing. In fact, I would go so far as to say that it is an uncomfortable and often-avoided conversation even when it does come up in our families, friendship groups or more broadly. But, what I have found out, and, in fact, what I thought to be the case in my electorate, is that people have strongly held views about what choice they would like to have at their end of life if they were faced with a terminal illness and were experiencing irremediable suffering.

Importantly, this legislation before the house needed to meet twin objectives of providing compassion and dignity for people facing death and ensuring that there are adequate safeguards in place so that no person is being taken advantage of. In this bill, both of these objectives have been achieved. Let us be very clear from the onset: people would rather choose to live than to die, but when faced with death, some may wish to choose voluntary assisted dying. This choice could be for a number of reasons, and, if nothing else, it is a way that that an individual may be able to feel that they are able to gain back some form of control at the end.

The legislation that is before Parliament is not something that people have to choose, but the conversation that we are having right now is about legalising the choice about how a person may choose to end their life. For those who are suffering a terminal illness where death is imminent, it is a decision that they should be able to make. They are already on a trajectory that, sadly, means they will pass. The question is: what will that death look and feel like? It is a personal choice and one that each individual should be able to have the ability to make. For those who are facing a diagnosis of a terminal illness, it is devastating. We have good palliative care services that are available. We acknowledge in this debate the fact that whilst we as a government are investing significantly in palliative care services, for some this does not provide a reprieve; it just does not work. But it should not be a one or the other decision.

I have taken time to consult my community so that I can stand here and say that I am representing the views of Joondalup. Over 80 per cent of the Joondalup community support this legislation and I will be supporting the bill. For me to be able to arrive at this decision, I took the time to understand the views of my community. I sent a paper survey to the entire electorate of Joondalup and advertised and hosted a joint forum with Hon Alannah MacTiernan, which was attended by Amber-Jade Sanderson, former federal MP Dr Mal Washer and, of course, Dying with Dignity Western Australia. Thank you to the speakers but also to each and every one of the 340 residents from the northern suburbs who came along. The sentiment of the attendees was overwhelmingly in support of voluntary assisted dying, with many personal experiences shared. I ran an online survey, doorknocked, phone called, held mobile and open offices and made sure that I took the calls and the meetings when local residents wanted to speak to me on this issue. I have attended many of the presentations made available to us as parliamentarians. The sentiments in Joondalup reflect those of the broader community. I note that some in our community wished that this legislation went further with regard to people suffering from Alzheimer's or dementia, but they also recognised the importance of this piece of legislation and the fundamental principle that a person accessing VAD must have the cognitive ability to make that choice at their end of life.

Rather than spend my time here in this place talking to the very important elements of this bill before the Parliament, as it is readily available, I want to take some time to convey to members the views from Joondalup. Whilst I cannot read every comment, I will read those that convey the general sentiments of my community, and I will include the alternative view. I will read them as they have been given to me.

One respondent said —

If people feel that their health is such that they have a painful horrible existence it should be up to them if they wish to terminate their life and go out in a peaceful manner with friends and family around.

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Another respondent said that we need this legislation: “To provide people with dignity and choices.”

Another respondent said —

Quality of life issues. We are kinder to our pets and try to stop them from distress. Why can't I choose when I've had enough and be remembered for the person I was, not the skeleton or hinder I am lying there in pain ... Let me family and friends remember the best of times with me instead of the burden I became. It is my right to die with dignity.

Another respondent said —

I believe people have a right to choose. If they have decided they don't wish to live and endure physical and mental suffering, they should have the option of voluntary assisted dying. It should be their right and their choice.

Another respondent said —

Because even just knowing that there is a choice would be a comfort to those fearing years of pain and poor quality of life.

Another respondent said —

The suffering that some terminally ill people have to endure is in humane and here is no dignity left in the final stages

Another respondent said —

If a person has a terminal illness and their wish is to die by a way of their choosing then their wishes should come above any other consideration.

Another respondent said —

Having seen my mother die on a hospital administered “nil by mouth” method and last for 7 days in this state—note—not comfortable at all—very agitated and on day 5 wake and speak to me about her pain I feel that we owe more to our elders, to our loved ones. In my experience our hospitals are unable to care for people at the end stage of life—in fact they cannot prevent aged people from getting bed sores that penetrate into the bone. My mother begged me to “finish her off” something that I was legally and emotionally unable to do. I could not facilitate this for her through the current legal and medical system. Change is well overdue. For some palliative care is not the answer and as consenting adults we should be allowed the choice and manner of our demise.

Another comment from the survey states —

PLEASE push for our voices to be heard on this issue. It's not just about palliative care and terminal illness. It's about QUALITY OF LIFE. I want the right to choose what my family have to deal with if I become sick. I DO NOT want them to go through the pain and suffering I went through watching my most beloved person in the world die an agonizing death. This is INSANE! It causes enormous knock on effects to loved ones and family. Strain on aged care services and health care facilities. This is the number one thing I'm most passionate about so feel free to contact me if you need any advice from someone who has lived and breathed this devastation. Thank you for all of your help Emily. You have no idea how important this is for humanity.

I want to spend a moment talking about Joan, the wife of Ernie, a local Labor branch member. Ernie lost his wife just before Christmas last year. An article in *The West Australian* of 22 December, titled “Perth family share their mother's plight in support of assisted dying laws”, states —

While most families have been preparing for Christmas, Joan Ellery was waiting to die, surrounded by her distressed husband, children and grandchildren.

...

It was confronting to see the mother of five, grandmother of 13 and great-grandmother of 20 who was being given just enough morphine to keep her comfortable.

...

For her family, the hope of end-of-life laws that would have allowed her death to be hastened came too late.

...

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“She was the most beautiful, hardworking mum to our kids and I was very lucky to have her—but she’s not really here any more and she would have hated that,” Mr Ellery said on our visit. “We discussed euthanasia many times and she was clear that she did not want to stay alive if she had no quality of life.

...

“For the last six months, Mum hasn’t known who I am but sometimes she looked at us as if to say, ‘Why aren’t you helping me more,’ she said. Ms Ellshore said her mother should have been given the right to die with more dignity. “There is no quality of life if someone is bedridden, has to be changed and be fed like a baby, and they have no awareness of what is happening around them,” ...

Just two hours after the visit by the journalist, Joan passed away.

I received some diary entries from a wife who was struggling as her husband was passing away in front of her eyes. According to my notes, she wrote on 20 January this year —

The last 27 days of my life have been horrendous in so many ways, it’s called having to face life and death circumstances, making the call and standing your ground in the name of humanity. In the silence I question the long road travelled, does anyone truly understand the journey, of heartache pain and suffering. Yes some do, but we need to unite as one and bring about Change, for our many loved ones but also for our end of life wishes. Addressing them by all coming together, will mean having our voices heard and that makes the difference. It means a better future for all who follow, bring about change in the name of humanity and dignity. For those who do not want Voluntary Euthanasia, I respect your decision, therefore respect my choice to choose, how, what and why. Respect is understanding that each individual is different and that they are entitled to their opinion in making a decision, but most importantly having control over their end of life wishes. It is through life experiences that we become more knowledgeable and our determination forces us to address the injustices of society.. therefore life is meaningless if we sit and watch the suffering of our loved ones and do nothing about it. God gives man a voice and a choice to intervene, take the stand in the name of mercy and one day you may experience all that I am speaking about, only then will you understand. We are not powerless to bring about change where love is concerned in the name of mercy we should never be afraid to speak the truth for the benefit of the less fortunate in their final hours of need. It is through seeing the pain of life that we become doers, ready and able to bring about change, for the benefit of all. I have asked myself the question, Do I want to suffer ? The answer is no, therefore it is my choice to choose, it should be my given right and mine alone.

I have had profound conversations with people from Joondalup and acknowledge that people have very strongly held views on this issue. I respect everyone’s personal views, even though I sometimes do not fully agree with them. I have spoken to people of faith at their doors. I recall a recent conversation I had not more than a fortnight ago with a gentleman who, when I told him the topic of conversation and the reason I was stopping by, quickly told me that he is Christian and does not support the legislation. He held the view that only God will determine when it is a person’s time to pass this earth. Conversely, I have spoken to Christians who have said, “My God is good and would not condone needless suffering.” Others have told me that they would not choose the option themselves, but would not be the ones to stand in the way of someone having that choice should they want it. I have heard people say, “Get on with it already! It had better pass! If I was dying, I would want the choice.”

As I mentioned, not all the submissions that I received or people I have spoken to were supportive of the bill, but I think it is important to understand the alternate view and respect those who hold it. I recently received a letter, one part of which read —

As a nurse I have worked in many areas, including care of the terminally ill and care of the elderly. PALLIATIVE CARE is the **ONLY** path to take. It is the only safe, loving, dignified, effective and honourable way of treating anyone of any age, in any such situation.

Another person said that they believe that any situation in which someone is assisted to take their own life or have their life taken by another person is morally wrong. Others have commented that any laws such as this will always lead to abuse, as has happened in other countries; that there are many other reasons against it; and that doctors are against the legislation. Another person said, “We shouldn’t kill people; it’s just that simple.” Although I understand that there are alternate views such as this, I say to those who do not support voluntary assisted dying: just do not choose it. But will they be the ones to stand in the way of giving other people that choice? We have to remember that this bill will provide an opportunity to show compassion and dignity to those who are suffering and for whom death is imminent.

This bill is the result of extensive consultation that has taken place over the past two years. A joint select committee inquired into end-of-life choices and, after 12 months, tabled its report, “My Life, My Choice”. The report reflected broad community agreement about the importance of individual autonomy and choice over end-of-life matters. The

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committee recommended that the government introduce legislation for voluntary assisted dying. One recommendation of the report was that a ministerial expert panel be appointed to develop voluntary assisted dying legislation in WA, and its final report was presented to the government. The reason for my mentioning this process is to highlight that throughout the formulation of this bill, consultation was fundamental and extensive. In addition, the bill includes the important and stringent qualification of having 102 safeguards.

Other jurisdictions, both internationally and within Australia, have dealt with this issue. We need to remember that although we are discussing this bill in Western Australia and it is our own piece of legislation, the topic is not just ours, nor does it stand alone. It is an issue that many countries around the world have addressed and which many communities are asking their parliaments and elected members to consider. The bill before us is the right bill for WA and one that Western Australians are asking for.

I congratulate the joint select committee and ministerial expert panel for their extensive work and consultation, which has enabled us to arrive at this bill. I thank those who have taken the time to brief MPs on this issue, including national and international guests and experts. I say well done to Dying with Dignity Western Australia for its public campaign and to all others who have been involved.

[Member's time extended.]

Ms E. HAMILTON: I say to those who are active on this issue in my community and who support this legislation that we need this bill to pass both houses of Parliament. I have concerns about the passage of the bill through the upper house. We need to ensure that all MPs are given the opportunity to vote on this important piece of legislation in this Parliament.

We all have a story of a loved one who has passed and whose memory lives on, but whose death is remembered with a heavy heart. There are the questions of: What if there had been another way? Why did it happen that way? What could have helped or have been done? Why did they need to suffer? I know I have those questions. Some of our colleagues and members of our communities, friendship groups and families are struggling with this issue right now. To those people I say that I hope we can say before the year's end that there is something else to consider—just another option and choice at end of life, when so many already feel so helpless.

I want to thank my community for the time they have taken to convey to me their views on voluntary assisted dying. Although I know that not everyone will agree with the decision I will make in this place, it is a decision that I have not taken lightly and one that I have ensured reflects the majority view of the good people of Joondalup.

I return to my first remark: it takes a bold government to deal with a complex issue like voluntary assisted dying. Yet here we are, doing what is right. I say yes to providing people in our community who are suffering with the choice to end their life with dignity. I commend the bill to the house.

MR P.J. RUNDLE (Roe) [11.30 am]: I rise to speak to the Voluntary Assisted Dying Bill 2019. I congratulate the government, the Premier and especially the Minister for Health for bringing this bill to Parliament for debate. It is a subject that should have been debated for many years and I think it is time to act, so well done to the government for bringing it to Parliament. I acknowledge also the Joint Select Committee on End of Life Choices chaired by Amber-Jade Sanderson, MLA, and also the Ministerial Expert Panel on Voluntary Assisted Dying, which was chaired by Malcolm McCusker, AC, QC. The work of both of those bodies is extraordinary. I thank each member of both those panels for their commitment to the task. I know it has been a long task and one that is very difficult, and I think they have done it well.

From personal experience, I am aware of the amount of consultation that has taken place. My mother was one of those who was keen to talk to the initial joint select committee. She lives in Albany. It was important that the committee ventured out to the regions and gave everyone their opportunity to tell their story. Mum was certainly happy to tell her story about her sister and how she felt about voluntary assisted dying. The committee handled it in a very private and compassionate way. It was important that the ministerial expert panel increased its consultation into the regions. Our party room met with Malcolm McCusker and the panel agreed to increase its consultation through the community resource centre network. That gave people in the regions the opportunity to have their say on the recommendations of the panel.

As will be the case for all members in this chamber, death is something that is personal. We have all witnessed a bad death or we know of someone who has been through it. Hopefully we have all witnessed good deaths that have been peaceful and painless for the person, surrounded by family. Perhaps they have died quietly in their sleep; that is utopia. Unfortunately the reality is that that way of dying is not true for everyone. We enter this world, decide on our fate throughout our entire lives and at the last hurdle that choice, that decision on how we die, is left to the government through laws. My office, like everyone's here, has been inundated with community and constituent opinions on the subject. Many and varied groups have argued their positions with research and statistics, which in some instances are interpreted in ways that reflect their stance. I have read them all. It is an emotional debate.

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There is no way we can make these decisions in a purely objective way. The correspondence we have received is emotional. Dying represents grief and we cannot deny that the act of death can be traumatising for everyone concerned. It is critical that we look at this debate rationally, logically and ethically, because we are asking people from the medical profession to act on our behalf as lawmakers, to completely disregard their most sacrosanct vow to preserve life. I am not a clinician but I will, like everyone here, die at some stage. I cannot predict the way I will die, but this bill has forced me to consider my options. I support the notion of the exercise of free will, of choice.

I acknowledge Belinda Teh in the Speaker's gallery today. Belinda walked across Australia and was quoted as saying —

My mother died in a way that will haunt me for the rest of my life. There are some things we cannot change and there are some things we can.

I congratulate Belinda on her advocacy. It was great to catch up with her yesterday in the courtyard.

Recently, I attended the premiere of the film *The Broken Hearted* and was particularly moved by some of the family accounts of the slow and painful deaths of their loved ones. At the premiere I met Kirsten Whitby, who was unassumingly talking to me, the member for South Perth and the member for Baldivis prior to the film. It was to my surprise that she was the first person featured in the film. I thought she spoke so well about the tragic circumstances of the end-of-life experience of her husband, Darren—the cousin of the member for Baldivis. That moved me.

I recently noted Howard Sattler going public about how he would like to end his life and some of what I thought were unfair letters to *The West Australian* from people trying to dictate to him about what he should do with the end of his life. To be honest, some of those letters were appalling.

More recently, Dr Colin Clarke came forward and talked openly about how he would like to end his life in a way that he can control, with his family around him. His wife is a qualified nurse, and his children are in full support. He has mesothelioma and as a medical doctor knows better than most that his life will be cut short and will not end in a pleasant way. It is important that we take on board his comments given he has only a short time left in his life. I note also the comments earlier today of the member for Warren–Blackwood whose brother was also afflicted with mesothelioma. He spoke about his family and the way Geoff would have liked to end his life.

I know of many accounts of painful deaths. Stories relayed to me from my constituents are difficult to listen to. The personal accounts from members in this chamber reflect on experiences that are terribly sad. I listened to the Leader of the Opposition today, and the Minister for Transport and the member for Perth last night, and some of the examples they gave are obviously very close to their families. I do not want to dwell on individual cases but this one was close to my family. I would like to give an account of a family friend, Mary Goyder, who had a fall in her unit. She had lived independently since the death of her husband 10 years earlier. Mary made up her mind that that fall was her journey to death. For four weeks her family watched her slowly go from chatting to them in her hospital bed to two weeks later being taken off fluids and food, and then another two-week wait until her body starved to death. The body does many physiological things that are very unpleasant to watch, and with the family on an around-the-clock vigil for their mother, this was traumatising. The attending palliative care doctor who came in for five minutes each morning said that his job was not to end Mary's life, but to make her death more bearable. The two weeks of that slow death were unnecessarily traumatising for everyone, including the nursing staff, and ultimately were the lasting memory for her family. It was absolutely not how Mary would have wanted to have died if she had been given the choice. There are many more instances that I will not go into, but I cannot with good faith in this debate ignore all those accounts. It is impossible to know the lasting effects of those acts on the families. I know that if they had had a choice about how their loved ones had died, it would not have been like that.

Suicide is an option for ending your life because there is no other way. It is not an option that we should be accepting. At the very core of that decision is that the person wants to die before their natural end of life. Suicide is lonely, brutal and sometimes unsuccessful. I have friends who have had family members die from suicide. They have never recovered from this.

As the Premier mentioned yesterday, Clive Deverall made the ultimate statement of support of voluntary assisted dying by taking his own life on Western Australia's last election day, saying in his note: "Suicide is legal, euthanasia is not." Mr Deverall was the highly respected former head of the Cancer Council WA and spoke in an interview of the reality of those who had symptoms that could not be controlled by palliative care. It was a powerful message that he sent on our election day in March 2017. I have dealt mainly with the family who are left to deal with the traumatising events and acknowledge that their pain is significant and longstanding. Interestingly, one of the arguments made by groups against voluntary assisted dying is that a family may coerce a dying person into early death to get hold of their inheritance or alleviate the burden on the family. From what I have read, it is completely the opposite. When a dying person wants to access voluntary assisted dying, the families are the ones who try to

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reason with their loved one to not go through with it. Not only is the dying person trying to access early assisted dying through the law, but often they have to argue their choice with their family.

A friend recently lost her husband to cancer. Mark Davis was a teacher at Narrogin Senior High School. He was only 58 and he was strong and healthy. His cancer was kept at bay for many months and he continued to work and be the father and grandfather who everybody loved so much. At the end, his cancer was extensive. He endured unbearable pain and in his final few days he told his wife that if there was a box to tick for euthanasia, he would have ticked it many times. When I asked whether I could use his name in my contribution, his wife, Chris, said that Mark would have been so happy to have his say. He strongly believed that an individual should have the choice. During the final stages of Mark's illness, he spoke frankly with his family about the need for other options. How can we, who are healthy and pain-free, sit here and make a judgement on this kind of suffering? Our perspective is based on what we have seen, heard and imagined. We cannot know exactly what goes on in the minds of people who live in constant pain and whose pain cannot be relieved. We cannot in all honesty make a decision about their life. It is irresponsible of us to imagine that we can. But what we can do is give them a choice to determine their own death.

Mental illness will be discussed during this debate. People have options with living wills and an advance health directive. However, neither allows access to voluntary assisted dying. People with dementia and chronic mental illness may want to determine how they wish to die while they have the capacity to make that decision. Minister for Health, I would like this option to be considered in the future. My view was consolidated after visiting many dementia wards throughout regional WA. I understand that it is not in the mix at this stage but it is something we need to consider down the track. We can determine how we want to die but the current legal system does not allow such a person's wishes to be met.

Palliative care is at the heart of this debate. I know from experience that palliative care is exceptional but not always effective. I know of people in my electorate who have not bothered with treatment for chronic disease because it is just too hard. As I mentioned during the private members' debate on health only a week or two ago, we have a perfectly good oncology ward at Narrogin Health Service, but eligible people cannot be treated there because apparently no oncologists are available to supervise treatment. The Minister for Health knows that I will keep reminding him about this. We have to do better in regional areas. Given that the facility has been built and is available for use, we need to work hard to get oncologists and doctors to that area. We have to provide the palliative care resources that people in Perth can access. Many people have spoken about it and others will speak about it, but at the very least we have to provide pain-free options for people in the regions so that they can stay close to their families and die with dignity and without anxiety. We have established, through research and anecdotally, that palliative care cannot help a small percentage of terminally ill patients. However, it can alleviate pain and suffering in nearly all terminally ill patients. We need to be conscious of the need to increase palliative care funding so that patients are not driven to other means of dying. Some people want to die at home with the support of palliative care and there is no reason why people in the regions should not be able to access this level of care because of where they live. The element of dying at home should not be overlooked. I disagree with the notion that accessing voluntary assisted dying means that people must die in a clinical facility. Dying at home in peace and in a familiar environment surrounded by family is an important part of this dialogue.

It is my understanding that the current laws put clinicians in a difficult position. In a small amount of cases, they are unable to give sufficient medication to make their dying patients unresponsive to the pain in case it kills them. I know in the past that people have relied on morphine doses to hasten death. Families are asked whether they are okay with increasing the dose and, of course, the families say yes because they are already traumatised by the process. This is unlawful. Doctors and nurses put their careers and personal ethics on the line. This practice does not help anyone. Access to palliative care prior to decision-making may ensure that those who decide that they cannot tolerate their future lives can make a decision from a position of support and in as much comfort as possible. This would negate the argument used by people opposed to voluntary assisted dying that an end to life is often desired by those lacking effective and bearable palliative care. Only then will we be sure that their choice is not clouded by a lack of access to appropriate care. To validate this requirement, investment in palliative care that can be accessed by people in the regions is an imperative. Regional patients who require palliative care should not be disadvantaged by distance. There must be a serious effort to improve palliative care in regional areas to minimise the argument that patients who seek voluntary assisted dying do so because palliative care is insufficient or unavailable.

[Member's time extended.]

Mr P.J. RUNDLE: It is interesting to note that people in jurisdictions in which voluntary assisted dying exists usually opt for palliative care. It is important to note that when people have been given a choice with the option

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to end their life available, they are happy to use palliative care. As I mentioned before, the part of the bill we need to be extremely careful of is ensuring that medical practitioners do not go against everything they have trained for. We will not be the ones who dispense a lethal drug at the end of life and we will not have to deal with the family and ensure that their emotional needs are met and we will not have to organise certification and end-of-life logistics. The power given to a doctor to perform this task should not be given lightly. I have had correspondence from doctors who are supportive of the bill, and for that I am grateful. Likewise, I have had correspondence from those who are not supportive. I appreciate their anecdotal evidence. Certainly, it is very polarising. Some are against the idea of assisted death and others see it as part of their profession to care for a person to the end of their life. This bill will not make anyone do anything that they are not willing to do. It is not unreasonable to say that most doctors and medical professionals have thought about this extensively. I am comforted by the fact that doctors who are not supportive of this legislation will never have to face performing a procedure that they are ethically bound to prevent. However, regional doctors are everything to everyone. They are friends with their patients. Many have given generational care to families in their town, and, with this in mind, I support any training that offers those professionals a safe passage if they are confronted with patients who wish to access voluntary assisted dying. They may or may not want to be a consulting practitioner for voluntary assisted dying but I feel that given their exposure to their community, they may require further support to assist them with a range of situations. Doctors living in small regional communities are not privy to the anonymity that city doctors experience. They are ingrained in a community and may be exposed to harmful, undesirable or emotive behaviour. The safety and support of our regional GPs is pretty crucial in my support for this bill because of their interaction with their community and, obviously, the Hippocratic oath that they have taken.

When we consider the dispensing of the drug, it is critical that we also consider the pharmacist who will be part of the process. I know of at least one pharmacist in my electorate who made a point of telling my office that they support the bill and would be willing to dispense the drug. I note at this stage that if this process is left to tertiary hospitals in the metropolitan area, our regional communities will be disadvantaged. I assume that as we go through the bill, the minister will make some allowances for the drug to be dispensed from places other than only tertiary hospitals. Otherwise, it will not allow for our smaller regional hospitals. I assume that will be taken into account.

Will this bill provide an overarching and supportive process that everyone in the metropolitan area can access? I have heard that telehealth could be used as an option. We all know that telehealth is a fantastic resource for most health-related incidents in the regions; however, for this issue, I am not so sure. I know that we are looking at the scenario with the federal Criminal Code and the use of the likes of telehealth, and that is something that needs to be explored at the consideration in detail stage. The chances of towns having one medical practitioner trained in voluntary assisted dying will be very low, and this bill requires two independent consultant assessments. Three requests from the patient are required with one written and verified by two independent people who will not gain financially by the death of the patient. Two of these requests will go to registered independent medical practitioners. That is a total of four consultations with highly trained specialists in this field. How will someone in Kukerin or Lake Grace, who is already burdened by the disease they are suffering from, access this requirement? I am not looking to soften the laws by any means; I am looking for funding to do what this government has always advocated for, which is for people to live and die in their own community. From the research I have done, access to voluntary assisted dying is not something that will happen very often. A small percentage of people suffering from disease will access this procedure. If people in my electorate are given the choice of dying with assistance, they should be able to see the independent medical practitioners in their own home or their local hospital. As part of this bill, there should be a portion of funding allocated to regional care that offers the same level of care as those who will apply in the metropolitan area will get, or as close as possible to what is offered in the metropolitan area.

This discussion was never going to be easy. I value the contributions of all my colleagues to this debate. I have felt a deep obligation to my constituents that I consider all the briefings, the consultations, the written reports, the available research and, of course, the valuable contributions from individuals and groups to my office. The obligation I have as a member of Parliament for a regional electorate also weighs heavily on my mind. The overwhelming indicators I have had is that this bill has been supported by a majority of people for many years. I absolutely acknowledge those who do not support this bill. As I said earlier, this is a very personal law that we are proposing, but I am confident at this stage that the procedural requirements are rigorous enough to protect the patient, their family and the medical practitioners involved.

Finally, I want to speak about a very personal experience in relation to my aunty, Norma Christensen. She was suffering from motor neurone disease over the last few years and was a very strong advocate of voluntary assisted dying. I recall Andrew Denton saying to me that he felt sorry for my aunty and our family because of what she would go through over the final months. He was exactly right. In her final months she was hoping to go to sleep and not wake up. Unfortunately, she fell over, fractured her hip and was admitted to hospital. From that point, she

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was not going to have an operation and was administered morphine. Her only method of passing on was to gradually starve herself over a two to three-week period. I spoke to her a week or so prior to passing on and she was happy for me to talk about her and her wishes. Her family, including her daughters, Diana and Lisa, and her sisters, June, Grace and Thelma, were also more than happy for me to speak about her situation. She was very pleased to talk to Hon Tjorn Sibma from the other place during his consultation in recent weeks. She really felt pleased that she had that opportunity to speak to him and also that I would talk about her during this debate. My parents are also very strong supporters and I speak to them quite often about it. Obviously, with the advent of my aunt's passing, it has been very close to home for them. They were disturbed at the prospect of filibustering and other things in the other place, and I am pleased to read in recent reports that, hopefully, that will not happen. I expect that the bill will be gone over in strong detail in the Legislative Council, but it is really important that it is done in an efficient manner and a respectful way. I look forward to that in the Legislative Council.

It is easy to say to those who do not support the bill that they do not have to do it, but deep religious and ethical beliefs define many of us. I admire those who have such strong faith; however, I do not believe that a belief that defines one should define all. My personal feelings aside, I have a responsibility to represent my constituency and this bill is by far the most responded to topic of conversation as I travel through my electorate. Overwhelmingly, the majority of those who have taken the time to write, email and call my office and speak to me personally are in favour of this bill. I would like to thank my electorate staff in both Narrogin and Esperance, and especially Sally in Narrogin, who has been on the front line and spoken to many constituents.

In conclusion, I say if you do not believe in voluntary assisted dying, then do not do it; however, do not prevent my constituents from having the choice. I commend the bill to the house.

MRS L.M. O'MALLEY (Bicton) [11.57 am]: The Voluntary Assisted Dying Bill 2019 is about choice. It is about compassion and dignity. It is about creating a regime whereby the terminally ill can choose to have control over the way they leave this life. It is a voluntary regime, and there are 102 clauses within the bill that ensure that is the case. This bill is not about the choice between life and death; it is about enabling the dying to choose a death that is dignified, with as little suffering as possible and surrounded by their loved ones, instead of a death that may be lingering and painful, or, being in a situation in which the terminally ill choose suicide—violent and lonely. It is not a bill to allow euthanasia, which is the act of one person taking the life of another to end suffering, nor is it assisted suicide, being the taking of one's own life when that person would otherwise continue to live. It is a bill to enable the terminally ill, the dying, to access the means to end unbearable suffering at the end of their life should they meet the criteria and, most important of all, should they choose to take that path. This bill is not about palliative care versus voluntary assisted dying. Both are vital to end-of-life care and end-of-life choice. This bill is about choice. It is right there in the title of the bill—voluntary assisted dying. Should this bill pass, it will be a voluntary regime. Self-determination and personal choice are core beliefs of our society and this bill is entirely consistent with those beliefs.

Like the members before me, I sought to understand the views of my constituency on voluntary assisted dying through survey, forum, on the doors and on the phones. It has been a great privilege to have listened to my constituents' stories of love and loss and the variety of views held across the electorate of Bicton on this issue. I deeply respect every one of those views—views that are overwhelmingly in support of the introduction of voluntary assisted dying legislation.

Madam Deputy Speaker, there are many ways in which the passing of this bill will positively impact on end-of-life choices in Western Australia. I will speak further on just two of these. Firstly, through the creation of a legal framework that will protect medical practitioners, providers of palliative care, family and loved ones from possible prosecution. It will bring important regulation to what is now a largely unregulated space. Secondly, it is my personal hope that it will reduce the instance of suicides by the terminally ill, to which one in 10 suicides are currently attributed in Western Australia. Death by suicide is solitary and violent and incredibly traumatic for those who are left behind.

On the first way in which a legal framework will lead to much-needed change to end-of-life care, I would like to relate the story of an elderly couple in my electorate—Pat and Mary. I do so because Pat implored me to after having approached me one day recently near my electorate office. Mary had been diagnosed with Alzheimer's disease some years earlier. Pat cared for her at home. Mary was hospitalised following a fall, and complications from the fall led to bronchitis, which became pneumonia. Pat believes that Mary's passing five weeks later was hastened by Mary receiving increased levels of morphine. Pat implored me to support the voluntary assisted dying legislation because no-one should ever make the decision to end another's life under any circumstances. Pat and Mary's story, unfortunately, is not unique.

The introduction of this bill will provide an important legal framework that will provide protection for medical practitioners and patients alike. I do not have a personal experience of watching a loved one die slowly and painfully and in great suffering. I have listened in empathy to the stories of those who have. What I do sadly have is experience of losing a loved one by suicide. Listening to the stories of those of loved ones dying of terminal illness choosing to end their lives were especially hard as I know firsthand the trauma of those left behind. I know

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all too well the wrenching sadness that follows the thought that in their time of greatest need their loved ones were alone. Suicide in and of itself is one of the greatest of human tragedies. It is horrifying to know that the terminally ill, due to the current deficiency in end-of-life choice, are choosing lonely, violent deaths. I wish for a future in which no-one dies by suicide. These deaths are, after all, entirely preventable. We do not yet have the answer to the broad issue of suicide prevention, but this bill will reduce the instance of suicides attributed to the terminally ill.

There are some absolute knowns—things that all of us understand to be true: that life is precious and that whilst everyone wants to live, one day we will all die. In this house, in the other place and out in our communities there are different views on voluntary assisted dying, and on this bill, but one thing we all agree on is that everyone deserves a death that is dignified, with the absence of suffering and being surrounded by loved ones. I ask all members to ensure the passage of the Voluntary Assisted Dying Bill through this place and the other without delay, and that the debate continues to be one of respect and kindness. I thank and acknowledge all members who have spoken already and will speak to this bill. For many, it is a raw and deeply personal thing to do. For all of us, we speak with the knowledge of the great responsibility entrusted to us as legislators to do the right thing by the people we represent. I support this bill. I will be voting yes. I sincerely thank all those who have campaigned and worked tirelessly and with a great diligence to bring this bill to the house.

[Applause.]

MS A. SANDERSON (Morley — Parliamentary Secretary) [12.05 pm]: I rise to make my contribution to the Voluntary Assisted Dying Bill 2019, and I speak strongly in support of this bill. I start by commending the Premier and the Minister for Health for their unwavering leadership on this issue. As most people know in this place, I chaired the Joint Select Committee on End of Life Choices. Medical intervention is giving us more time with our families but it is delivering longer periods of dying, often with debilitating symptoms. I was genuinely surprised by the scale and extent of the end-of-life suffering that is occurring across our community. Over the past two years, I have literally heard hundreds of personal intimate accounts of people who have borne witness to the most profound suffering of their loved ones. People poured their hearts out and told harrowing stories of under-medicating, over-medicating, adverse reactions, severe agitation and of frail people suffocating in their own fluids while their loved ones looked on helplessly—sometimes at home, sometimes in a specialist setting, with access to all that palliative care has to offer. It is going on behind closed doors in people's homes, in hospices and hospital settings. With this experience, those left behind are left with an intense grief compounded by the trauma of witnessing a horrible death. The sense of guilt and helplessness of those left behind is palpable.

Any member of this place who has genuinely engaged with their community on this issue will not have escaped the horror stories. Those who witness this suffering are also left with a conflicting mix of emotions: on the one hand, a deep gratitude to the staff and organisation that supported their mother, father, husband, and on the other hand, an anger and sense of injustice that this kind of suffering is allowed to occur in a modern medical setting. Experienced doctors tell us that they feel helpless and that they have let their patients down. I have absorbed every one of these personal accounts and we cannot let them be for nothing. We simply cannot let the status quo continue. It would be unconscionable for the government or for me to cut them loose to face whatever end they fear the most when there is a better, gentler and more humane alternative.

We now know from national coronial data that around 10 per cent of suicides in Western Australia are linked to chronic or terminal illness and that people are choosing to escape their pain alone and in grim circumstances to be found by relatives, neighbours and first responders. The number is consistent with statistics in the United Kingdom and the United States of America. These deaths are primarily by carbon monoxide poisoning, asphyxiation by plastic bag, gunshot wounds, overdose or hanging. Some are successful; many are not. I consider these to be the wrongful deaths driven by the current lack of options for patients and doctors.

During the inquiry, we heard evidence of health professionals in particular stockpiling medications to avoid a bad death. Bill Philips told us of his wife's condition and her deep fear of her dying of a ruptured bowel or a ruptured stomach. She was an experienced nurse and knew what was coming. She had been stockpiling opiates and made the decision to commit suicide. Bill was in the room with her when she took them, and made a promise not to call an ambulance. As a justice of the peace of 34 years, he was well aware of the consequences of aiding a suicide. But she did not die. After four days at home alone with her, lying in bed with her, it became clear that she was not dying and that the drugs were wearing off. He had to break his promise and call an ambulance. She went on to suffer a very difficult death. The McGee family lost their father, Joe. Suffering from cancer, he hung himself in the garden shed. He left a note for his wife: "Sorry about Christmas. I just could not hang on." Suicide is a legal option but only alone.

The current laws are not only bad for patients; they compromise carers and relatives who only want to do the right thing by their loved ones. The most strident objectors tell us that more palliative care is the answer, but we know from data collected by the palliative care sector itself, symptoms cannot be relieved and not everyone wants to be palliated.

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Up to five per cent of terminal patients will suffer when they die. Bone and nerve pain are incredibly difficult to manage and almost impossible to control. End-of-life symptoms of choking and coughing, especially for motor neuron disease patients, are some of the biggest challenges for palliative care, and some patients choke or suffocate to death. Not everyone wants to be treated with a cocktail of heavy sedatives and antipsychotics. That is the palliative care “toolkit” for complex cases. Specialists gave evidence that they will keep trying out different drugs on a patient until they get a result. It is an important pillar of our freedoms that no medical treatment is compulsory. Well-meaning objectors and some palliative care specialists are asserting that every terminal patient must have palliative care. Frankly, that should not be their only option.

A very experienced Western Australian neurologist who specialises in MND recently told me about one of his patients. She was in her 80s, with all the symptoms of advanced MND. With no other options to escape her suffering, she elected to starve herself to death. It is actually very hard; stopping eating is the easy bit, the hunger pains stop after a few days, but the withdrawal of water is the hardest, and she took 17 days to die. It was very difficult for her and her family who were with her. I have read many submissions and heard so many examples of people electing to escape their terrible symptoms by starving themselves to death. Although palliative care specialists told us that this is very rare and that it is actually just normal for people to lose their appetite, my observation from the evidence we heard is that they are either not being honest or in complete denial about the frequency with which this is happening. I have no reason not to believe the families and doctors who said their loved ones or patients died a bad death and palliative care was not enough. There is no vested interest in their stories—just sorrow.

One woman gave evidence privately of the horrific circumstances of her husband’s death in one of our best hospices. No longer able to swallow, begging for water and under sedation with an ever changing cocktail of drugs, he was often semiconscious, anxious, confused and restless. This was far from the peaceful death he had been led to believe would happen. He had four medication ports, two butterfly ports for breakthrough medication and a catheter. He was nursed intensively, with blood pressure and oxygen level checks, washing and sheet changes. He was moved and then moved again, all adding to the pain—any movement was excruciating. Uncontrollable respiratory secretions left him unable to breathe properly. Eventually his communication was limited to, “I love you” and “Get me out of here”. There was 17 days of this until he died. His wife was left deeply traumatised and unable to cope with her grief. Her greatest regret was that he did not have another option.

No-one could hear these stories again and again and think that the status quo should remain and that there is not something terribly wrong with the current system. One palliative care specialist recently wrote to all members of Parliament describing these stories as “fake news”. Fake news—I have heard many offensive things in the course of this debate, but I found that truly shocking. To deny the real experiences, the suffering and trauma that is occurring in our community, I find to be heartless and dishonest. It is true that some in palliative care truly believe in the redemptive power of suffering, that in most instances unresolved issues are the cause of end-of-life suffering and that people should be conscious to face their deaths regardless of the suffering that they are enduring. I, and I think most reasonable people, would completely reject that notion. It is a notion derived from religious ideology and has no place in a modern healthcare setting. The choice to spend your last days and hours in a loving environment surrounded by your loved ones and pets, while you are coherent and relatively pain free, is a rational and reasonable choice for people who are dying. There is nothing noble about suffering in the name of someone else’s ethics.

Terminal sedation is a current palliative care practice—the sedation of a patient until they pass away—but that is only available if a person is lucky enough to get a physician who will provide that treatment. Many people find themselves with doctors, or in a facility, whose policies do not support it. We know of many incidents of under-management of pain and under-medication because of either fear of the law or the ideological position of the doctor. Terminal sedation is usually applied with the withdrawal of all food and water. Our committee heard evidence of patients continuing to contort and wince in pain while sedated; others had adverse reactions to morphine and other drugs. In the words of one of WA’s most respected neurologists, “They make you earn your death.”

Finally, the important principle of informed consent is lost in this treatment. It is ultimately the decision of the doctor, sometimes in discussion with the family, when the patient’s final conscious moment will be. The community has fundamentally rejected this concept; people want control over their last conscious moment when facing terminal illness. We know that doctors are ending their patients’ lives to end their suffering. Anonymous surveys over the years have shown this to be the case. This is happening now. They do it because people beg to be put out of their misery. They can see the suffering and they are compassionate and humane doctors. Our current laws would condemn these doctors under the Criminal Code. This bill will provide a legal and safer framework for all health professionals to work under.

My personal observation on the most strident objectors to voluntary assisted dying is that they do a lot of talking and not a lot of listening. I would firmly place the Australian Medical Association in this category. The WA branch of the AMA opposed this bill before it was even drafted. Inflammatory statements and scaremongering have characterised its contribution to date. Claims that WA would be a destination for so-called VAD tourism is an

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absurd prospect. Another recent claim is that the government is considering this as a “cheaper form of health care”—equally absurd, also offensive. Michael Gannon recently claimed that there are no safeguards in this bill to stop VAD clinics setting up in shopping centres. These statements insult our intelligence. The AMA was forced to print an apology in its member publication *Medicus* to the McCusker-led ministerial expert panel, which included the current president of Palliative Care WA, palliative care specialists and two former AMA presidents, for claiming they were “puppets of the government”. Malcolm McCusker, QC, former Governor of this state!

We have also heard from the AMA that end-of-life issues are far too complex for ordinary people to understand and that it is really for doctors. The days of “doctor knows best” are gone. Patient autonomy is a critical feature of modern medical ethics. Objecting doctors often quote the ancient Hippocratic oath of do no harm, which dates back to 470BCE. Some aspects of the oath survive today, but many aspects have no application in modern medicine. The more contemporary Declaration of Geneva builds on aspects of the Hippocratic oath and has been adopted by the AMA. A key feature of the physician’s pledge is: I will respect the autonomy and dignity of my patients. Providing a safe and compassionate death for terminally ill patients is fully in keeping with modern medical ethics.

It is heartening to see that the Royal Australian College of General Practitioners has taken a position of supporting patients to have a choice. Eighty per cent of Australian Nursing Federation members—those on the front line who spend more time than any other medical profession with patients and families and see their suffering—support voluntary assisted dying. Independent research commissioned by Palliative Care Australia shows that where voluntary assisted dying is legal, professional bodies like the AMA start from a position of opposition and move to a more neutral or supportive position. The Canadian Medical Association is one example of that. Palliative Care Australia’s research shows that every jurisdiction has also seen a significant increase in palliative care funding.

We have heard and will hear over the course of the debate so-called examples of wrongful deaths and the slippery slope in other jurisdictions. I say to members: when you follow the credible evidence, it leads you to only one place; that is, these laws have been operating in some jurisdictions for over 20 years without evidence of abuse or misuse. The so-called examples are anecdotal, not fact checked, would not qualify under this bill and in some examples the individuals are indeed still alive as far as we can ascertain. Articles by doctors making claims of abuse and misuse are almost always linked to a faith-based institution and, for whatever reason, these doctors choose not to declare the religious views that form the foundation of their opposition. Having a religious-based objection is valid, but is it not honest to declare your stance so that everyone is aware and can consider that when assessing the evidence?

The emotive term “slippery slope” is used to imply that something is out of control. This is just not the case; we know that this has been working well without abuse for many years.

I expect this bill, if passed, to be operating in the same form in 20 years. The abortion law has not changed in 21 years, and the legalisation of abortion has not led to a huge increase in abortions over time.

Some people say that on this issue, there is an elephant in the room—that is, the issue of steering and coercion. To those people I say that if there was an elephant, a highly trained group of expert handlers has now come in, taken that elephant out of the room and put it safely away. The bill has been shaped by an expert panel of the highest standards, and the safeguards that will be put in place will protect vulnerable people in ways that simply do not exist now. Coercion, elder abuse and other such matters are much more likely to happen under the current system, which has no safeguards, accountability or framework. In effect, opponents of this bill are arguing for the substandard status quo to remain, with no scrutiny, no accountability and no safeguards.

We know that the public overwhelmingly supports this bill and the concept and principles that underlie voluntary assisted dying. This is evidenced in the increasing number of jurisdictions now moving to legalise it—18 across the world. Three jurisdictions in North America in the last 12 months alone have moved to legalise it. This seismic shift in political sentiment has caused the anti-VAD lobby to develop a new strategy, as it is clear the community rejects religious arguments. The new approach adopted by the no lobby is: not this bill. We see that that is clearly the Australian Medical Association’s approach. It says to members, “We don’t object to voluntary assisted dying; we just don’t think this is the right bill.” It misrepresents elements of the bill, overreaches with an extreme hypothetical example to scaremonger, and then says, “We just don’t think this is the right bill. There are too many potential problems.” This is a well-established strategy used by the AMA and religious objectors, and we see that the AMA is already pushing amendments to what is an incredibly stringent bill. I believe the motivation is to make it unworkable; it is not genuine engagement.

I want to acknowledge those health professionals, doctors and palliative care specialists who have listened and changed their view. It is hard to walk back from a deeply and long-held position. For some on the ministerial expert panel, it has challenged the core of what they have been taught to believe and goes against the views of many powerful and longstanding colleagues. To their great credit, they have played an important role in shaping the legislation before us. The bill before us provides a conservative framework. It has been developed with the strongest clinical and legal guidance, drawing on the best of other jurisdictions, two years of intensive consultation,

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and with compassion at its heart. The fiercest criticism I have received is that it does not go far enough and is too restrictive. People with dementia want access to voluntary assisted dying. Dementia is the most prevalent neurodegenerative disease, and the suffering is real.

There are two important principles that underpin this bill. The first is the voluntary choice for an individual free from any coercion. The second is a decision-making capacity. I fully support the government's strong position on these principles. We have never gone further on this journey in Western Australia; for that, I give credit to the Premier, Mark McGowan. Without his leadership and unwavering support on this issue, we would not be here today. My committee delivered to him a monumental medical reform, requiring an enormous use of government resources to deliver it. It is a big ask of any government. It cuts across the political divide.

[Member's time extended.]

Ms A. SANDERSON: I have spent the last two years reading and talking about dying and terminal illness. The greatest lesson I have learnt from this is that, overwhelmingly, people want to live, and they will do anything and put up with the most appalling symptoms and side-effects of medications to do so. The committee visited palliative care patients in homes and hospitals. One of the most challenging visits for me, after weeks of gruelling hearings, was to visit a 42-year-old woman with multiple cancers and two and four-year-old boys. That was my age, and my son was two at the time. I am embarrassed to admit that I cried in her room when I met her. It was really the last thing that she needed. I have two big fears in my life. The first is losing one or both of my children; the second is leaving them behind. But if I have to leave them, I cannot bear the thought of leaving them behind with the kind of trauma that Belinda Teh has to live with every single day. If this bill becomes law, people will continue to die—that is a certainty—but far fewer people will suffer.

MS L. METTAM (Vasse) [12.24 pm]: I would like to start by thanking the many individuals on all sides of the debate who have contacted me regarding the Voluntary Assisted Dying Bill 2019, and who have shared their personal stories with me. I recognise that for many this has been a difficult consideration, as many think of their own friends and loved ones who have sadly passed or who are suffering from a terminal illness. I would also like to thank the many community and professional organisations that have contributed to this debate and these discussions, such as the Australian Medical Association (WA); Palliative Care WA; the very special Busselton Hospice Care Inc; the Western Australian Palliative Medicine Specialist Group; the palliative care team at Sir Charles Gairdner Hospital, who I had the privilege to catch up with; the Doctors for Assisted Dying Choice; and many individuals in the community who have contacted me to express their view on this legislation. I believe each and every group that has expressed an opinion about this bill has done so with a respect for life and for the individual. I believe great consideration has been given to this bill from all sides of the debate. I recognise that members of our community hold diverse and passionate views about voluntary assisted dying.

My decision on how I will vote on legislation to legalise voluntary assisted dying in Western Australia has been incredibly challenging, and is certainly one of the most difficult decisions I have had to make during my time as a member of Parliament. I have spent many months talking to my constituents, meeting with community organisations and responding to emails, letters and phone calls, and I intend to vote as a representative of the community that I represent, Vasse, in support of this bill. I am voting in favour of this bill so that people who are suffering from a terminal illness and who meet strict conditions have the freedom to choose voluntary assisted dying, should they wish. I am voting in favour of the bill because I believe that the overwhelming majority of people in the community who support this bill are doing so with an awareness and understanding of what it represents. People have a right to die with dignity if living in dignity is no longer an option for them. That does not mean that this bill does not represent significant challenges for our health system and for our community as a whole.

As I stated, I had the privilege to speak with many constituents over several months, one of whom is Peta Quinlivan, who was happy for me to share her story—an all-too-common story that is sadly repeated and is consistent with views I have heard from other constituents. This is an excerpt of Russell's story —

My husband Russell was ill for 20 years—ten of those in chronic pain, riddled with arthritis in his spine. Even after all that time, when he was first diagnosed with neuroendocrine lung cancer, he was ready to fight—to throw everything at it.

He was so proud, so brave.

Little did either of us know, he'd have just three months to live, and the last three weeks would be ghastly: Trapped in the trauma of pain beyond anything that could be medically treated, with neither dignity nor the capacity to communicate.

Before he was admitted to hospice, he was not afraid to die but he would say he was afraid of *how* he would die.

Extract from *Hansard*

[ASSEMBLY — Thursday, 29 August 2019]

p6088b-6116a

Mrs Liza Harvey; Mr John Quigley; Mr Terry Redman; Ms Margaret Quirk; Ms Emily Hamilton; Mr Peter Rundle; Mrs Lisa O'Malley; Amber-Jade Sanderson; Ms Libby Mettam; Dr Tony Buti

Before he was consumed in a world of nothing but pain—*absolutely nothing but pain*—he begged for release, to hasten the end. But under WA law, we couldn't help him.

He was monstered by his pain—physically, mentally and emotionally.

...

Russell was even stripped of comfort from human touch in his last weeks, as it caused unbearable nerve pain and his excessive body heat, from haywire hormones, deprived him from having any more than two people in his room at once.

He was promised that when going into hospice, his pain levels would be managed. But he was in the very small minority where his pain couldn't be treated medically. His doctors permitted, written in Russell's medical notes, "break-through" medication of extra morphine.

But under WA law, medics who attended to him in the middle of the night—his face in a locked grimace, his body contorted with pain—could refuse to follow the specialist's orders, on the grounds they feared any more morphine may be fatal.

In those last two weeks in hospice, I sat by his side day and night, too scared to sleep, fearing he would break his weakened spine—as happened to a man up the corridor—as pain shocked his body.

“Three years on and I still can't sleep properly, haunted by images of my husband reduced to a skeletal figure, in a nappy.

There was no mercy for my husband Russell—a deeply private man of a strong, athletic build; a surfer, a “specimen of splendour” who would turn heads at the beach and loved the outdoors.

...

The people of WA need to be allowed to choose medical assistance to ensure a more hasty and dignified death for those who suffer like my Russell did.

She went on to tell of how Russell would have wanted a choice and how she was certain of what his choice would have been.

The decision to support this bill comes from compassion and mercy. It is about the opportunity to provide individuals such as Russell a calm and painless death surrounded by loved ones. However, as I stated earlier, this bill represents significant challenges for our health system and our community as a whole. Western Australia is only the second jurisdiction in this country and the thirteenth in the world to introduce voluntary assisted dying legislation. It is important to recognise that only a small number of people will choose to access this legislation, but for those who do, it will be a significant decision for them and their families. It is also important to keep in mind that the majority of people suffering from a terminal illness will not choose to access voluntary assisted dying, and that Western Australia shares one of the poorest rates of palliative care specialists per person in the country at 0.57 full-time palliative care specialists for every 100 000 people. It is worth noting that we share one of the poorest rates of palliative care specialists with Victoria, the other state that has introduced this legislation. Using Palliative Care Australia's benchmark of two palliative care specialists for every 100 000 people, we should have 52 palliative care specialist doctors, at least 10 of whom should reside in regional WA. Instead we have 15 in the state, which is why it is essential that palliative care resourcing is improved.

It is an unfortunate reality that many of the tragic stories that have been heard in the media and from the public about terminal illness, will not be captured by this legislation. Given that only a very small proportion of those in the community will be eligible for voluntary assisted dying under this bill, it is essential that this government make a stronger commitment to palliative care. It is unfortunate that some of the concerns I have heard in recent times about the end-of-life phase for terminal loved ones involve poor experiences of palliative care. Sadly, access to palliative care is not equal across the regions. It is further limited in rural areas and almost non-existent in remote regions. The Joint Select Committee on End of Life Choices was told of people in regional areas who transferred to Perth to receive specialist palliative care treatment. I took the opportunity to meet with specialist Dr Anil Tandon and his team at Sir Charles Gardiner Hospital, many of whom spoke about the heartbreak of patients who are put in the position of choosing between staying close to home and receiving limited treatment and travelling to major hospitals in larger centres, often away from family and friends, to receive appropriate palliative care. There are also legitimate concerns around how the commonwealth legislation will impact the ability for telehealth services to provide advice in regional and remote areas.

I appreciate the Minister for Health accepting my request to meet with the team at Busselton Hospice Care—a team of over 100 dedicated volunteers from the Margaret River and Busselton coastal community who support voluntary assisted dying. I am pleased that the state government has provided an additional \$41 million towards palliative care in the 2019–20 state budget. However, I recognise that \$5 million is dedicated to building an aged-care facility

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in Carnarvon and another \$5 million will go towards the implementation of this legislation. I am keen to see how the balance of \$30 million will be allocated as a priority. We must not lose sight of the fact that more needs to be done to expand palliative care in this state, especially in the regions. Decisions made on end-of-life choices should not be made according to postcode and the quality of end-of-life care.

Before I close, I would like to note other concerns raised about this bill, largely from the medical profession that has a unique appreciation of what this bill represents. One concern of some in the profession is the lack of consultation. One local specialist wrote to me and stated —

I feel it would have been more appropriate to obtain a broad range of perspectives prior to progressing this legislation rather than asking feedback from practitioners such as myself in a latter phase looking at the mechanisms related to the proposed legislation.

I strongly feel this legislation does not provide an appropriate level of protection and safety for practitioners involved but more specifically and significantly for patients in a palliative stage of treatment.

He then went on to note the concerns of the president of the Western Australian branch of the Australian Medical Association, Dr Andrew Miller, that some specialists also had concerns about the absence of the requirement for a mental health examination, given the obvious impact someone's capacity to make an informed decision would have on this significant decision.

I have also heard very legitimate concerns about how this legislation will work in an environment in which there are many examples of elder abuse, especially in the context, according to the parliamentary Select Committee into Elder Abuse, that there are currently up to 75 000 victims of elder abuse in this state. This would be very challenging to legislate against, which is perhaps why I have heard so many concerns from the medical profession about this.

It is fair to say that I have also heard from many medical professionals and specialists from across WA, and my electorate in particular, who are very supportive of this bill. Some of them who acknowledge the current role doctors undertake in shortening a patient's life also have a firsthand appreciation that palliative care cannot always eliminate pain and suffering, which can sometimes lead to patients taking matters into their own hands. I note the report of the Joint Select Committee on End of Life Choices found that one in 10 suicides involve people who have a terminal illness, which is consistent with data taken from other jurisdictions and the last five years in WA.

There has been much discussion about the 102 safeguards in this legislation. I certainly believe that we need to be particularly careful with this legislation, given that it represents the hastening of death. This is why we need to ensure that the decision to access voluntary assisted dying is made solely and freely by the individual, not because of a lack of adequate alternative treatments or pressure from family members, and that any issues of mental illness have been considered.

We also need to ensure that our medical practitioners are both properly trained and have the freedom not to undertake voluntary assisted dying, out of respect for their own values. This is why the safeguards are so necessary and why the consideration in detail process needs to be treated with respect and with patience, because we as legislators must feel confident that this bill that promises mercy and compassion for a limited few does not do so at the cost of others.

DR A.D. BUTI (Armadale) [12.40 pm]: I rise today to speak on the Voluntary Assisted Dying Bill 2019 and I wish to acknowledge all the hard work undertaken by the Joint Select Committee on End of Life Choices, the Ministerial Expert Panel on Voluntary Assisted Dying and all involved in bringing this bill before the house. I would also like to thank all those in my electorate and beyond who have contacted me in person, on the phone, via email or through the post to present their views.

The nature of the conscience vote afforded to government members is one that I and my colleagues take exceptionally seriously, and I am sure all members of this house do. My journey to the position that I now hold on voluntary assisted dying and the bill we have before us has been long and convoluted. Until a few years ago, although I understood the calls for euthanasia and assisted dying, I personally was not in favour of legalising voluntary assisted dying. But since then, my research and interactions, plus examination of the bill, has seen a shift in my position. However, I still have concerns with one issue, which I will detail later in my contribution.

I will not be relaying stories of people I know who have died an awful death or have been denied dying with dignity. In the main, my focus today is on the philosophical and legal aspects of the bill and voluntary assisted dying. Such a discussion involves issues of morality, ethics, religious belief and political and legal theory. Among members here and in the other place there may be disagreement with the title of the bill. Although terminology is important, I dearly hope we do not get bogged down in consideration in detail on this issue. As the member for Girrawheen noted, the term euthanasia literally means "good death" or "dying well" from the Greek "eu", meaning good, and "Thanatos", meaning death. Some people, even speakers in this debate, may argue that the process this bill is dealing with cannot be referred to as euthanasia, but I am not sure that is the case. Professor Cameron Stewart of the University of Sydney has stated that euthanasia is a general, non-legal term that covers a variety of legal

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and illegal behaviour and it involves voluntary assisted dying in which a person competently requests and receives help to die. Like the member for Warren–Blackwood, I also refer to the Australian Human Rights Commission paper, “Euthanasia, Human Rights and the Law”, which states —

Active voluntary euthanasia—when medical intervention takes place, at the patient’s request, in order to end the patient’s life;

I think that compassion and love sits at the heart of this bill: love of our family members, love for our fellow community members, love for those in intolerable pain who are dying, who will soon be dead with or without assistance to bring closure to one’s life. But I want to make it clear: I dare not be self-righteous and say that love sits only with the proponents of the bill. This love can and has pulled people in opposite directions; some support the bill, while others oppose the bill. This bill is motivated by love and compassion, not ill motives, greed or money. On the radio yesterday morning, I heard a talkback caller saying that the bill is all about saving money for the government by taking attention away from palliative care. That is not so. I know the Minister for Health; I know the Premier; I know Tony Simpson, a former member for Darling Range, who was one of those responsible for bringing the issue of voluntary assisted dying to the forefront of political debate, along with others such as Hon Alannah MacTiernan, whom I also know well. I can assure members that when it comes to supporting this bill and voluntary assisted dying, those I have just mentioned are not motivated by money or budget savings; they are motivated by love and compassion.

Some people may say that this bill is all about dying with dignity, and so it is. But we could just as correctly equate dying with dignity with the rejection of a bad death. US legal academic John B. Mitchell has written —

In this bad death narrative, the person is in pain and soiling himself, with tubes and machines humming away (although, if these are life-supporting tubes and machines, the patient can request they be removed and shut off). Why must a patient endure this? Why can the patient not exercise his autonomy and choose to end this mockery of his existence with the assistance of ...

What we would call voluntary assisted dying. To permit any less denies the patient the choice to die with dignity.

Lindy Willmott, Andrew McGee and Ben White, in an article published in the online journal *The Conversation* on 14 November 2017, reported that four major themes of objection were raised by MPs in the Victorian parliamentary debate on its voluntary assisted dying legislation. The themes were: first, the bill does not have adequate safeguards to protect the vulnerable; secondly, legalising assisted dying presents a slippery slope; thirdly, palliative care services must be improved first; and, fourthly, a doctor’s duty is to treat, not to kill. I want to tackle these objections now, as I have also heard the same objections in the lead-up to this debate, although I will leave the protection of the vulnerable to the end of my contribution, as this has a personal dimension for me.

The slippery slope argument contends that even though our model, like the Victorian model, is currently a conservative one, that does not mean it will not evolve over time. But our bill is to a large extent modelled on the Victorian model, which, in turn, is modelled on the Oregon Death with Dignity Act, which has not been amended since it was enacted 20 years ago. That is the jurisdiction we should compare ourselves with, not the Netherlands or Belgium, which have a very different system and model from what we are seeking to introduce. But in the end, it is up to the legislators of this Parliament to ensure that we do not go down the slippery slope. That is our responsibility and the responsibility of those who follow us in this place.

Opponents of the bill and voluntary assisted dying will say that the focus should be on palliative care and that only when we fix that up can we move on to looking at voluntary assisted dying. I agree that palliative care should be the main game and main focus. It is. The Minister for Health has a focus on palliative care and has increased funding in that area. Of course we need more funding for palliative care, but that will happen whether or not this bill is passed. It must also be realised and acknowledged that there will always be a small percentage of people who are dying and for whom no amount of palliative care will ease their pain and suffering. For those who are opposed to this bill and say instead that we must fix up palliative care before moving on to legislating for voluntary assisted dying, I ask: When will we know when palliative care is fixed up? If we did reach that standard, would they still be opposed to voluntary assisted dying? Some may respond that yes, they would support legislation in this area, but I believe others, for various reasons, would never support legalising voluntary assisted dying. We can do both—legalise voluntary assisted dying and improve palliative care—but remember that there will always be some who are suffering who will never find comfort with palliative care.

Doctors should not harm, and as the authors of *The Conversation* article state —

This argument holds that an assisted dying bill will undermine the nature of the doctor–patient relationship, which is based on trust. Arguments in this theme also contend assisting patients to die is the very antithesis of what doctors do.

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Reference is often made to the Hippocratic oath, noting that it says, “first, do no harm.” But it must be realised that under this bill, the time of healing has passed. The person is terminally ill and will inevitably die—actually, death is imminent. What counts as harm depends on context. For example, as noted in the article on *The Conversation*, we do not normally think surgeons violate the Hippocratic oath when they cut into the skin during life-saving surgery, yet cutting into our skin is a form of harm. We accept this harm because it is outweighed by the fact that the surgery is life-saving. The author similarly argued that helping people die more comfortably is not a form of harm but is actually a benefit. In fact, not allowing for voluntary assisted dying may cause harm.

Before moving on, I should mention the doctrine of double effect. That is when doctors are legally allowed to administer painkilling medication to patients even if they know that death will occur as a result or that there is a high risk of death occurring. It is not uncommon for healthcare professionals to risk administering high doses of drugs such as morphine to control pain, even though it is foreseeable that there is a reasonable likelihood that the dosage will kill the patient. The intention and motive is to control pain, although resulting death is foreseeable. This is allowed as the intention is to relieve pain and suffering. If death occurs as a result, it is viewed as incidental to the intention to relieve pain. It seems somewhat strange to allow the doctrine of double effect to occur but not allow a tightly legally controlled voluntary assisted dying regime.

Debate interrupted, pursuant to standing orders.

[Continued on page 6127.]