

Mr Terry Waldron; Dr Judy Edwards; Dr Elizabeth Constable; Mr Peter Watson; Dr Steve Thomas; Mr Terry Redman; Mr Mick Murray; Mr Paul Andrews; Mr John D'Orazio; Mr John Day

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**ACTS AMENDMENT (ADVANCE HEALTH CARE PLANNING) BILL 2006**

*Second Reading*

Resumed from 15 August.

**MR T.K. WALDRON (Wagin)** [12.19 pm]: I will speak briefly about the very interesting and informative debate that has taken place on this bill. I have certainly learnt a lot from it. This bill has become quite a personal issue for members. I compliment members who have spoken on it, as we have heard some very interesting speeches. I am not going to tell family stories, other than to let members know that my dad is nearly 88 years of age and he has talked about what should occur when he might reach a certain situation. I understand, therefore, what he wants me to do in that situation, and we have left it at that. I will probably talk to him a bit more about it on the weekend after further debate on this bill. I have not had a lot of feedback on this legislation from my constituents; in fact, I am surprised I have not had more. However, in talking to people around my electorate about the bill and in representing the electorate, I am confident that a strong majority of members of my electorate support the intent of the bill and the aims it is trying to achieve. I also support the intent of the bill; however, like many members of this place, I have some valid concerns about it. The problem I have, and probably many other members have, is that I am no medical expert. Having heard what members of this place with a medical background have had to say, I wish I had some of their knowledge when dealing with this bill. However, I do not have that background, and I am no ethics expert either. I guess I am just like everyone else. I am just a normal member of the community and I feel that I am not qualified to speak on the complex medical and ethical issues of the bill.

As I said, I agree with the intent of the bill and I will support the bill. As has been cited by a couple of other speakers, the first paragraph of the minister's second reading speech states the intention of the bill as follows -

... to reform the law relating to medical treatment for the dying. Although the government does not support euthanasia, terminally ill people deserve the right to die with dignity and have their wishes about medical treatment respected.

Like other members, I do agree with those words. I am not a supporter of euthanasia, such as is in the Northern Territory bill. However, people who are dying, particularly elderly people, have a right to express their view on the treatment they are prescribed, and they have a right to die with dignity.

I also feel that there is one point that the minister should take into account; that is, the need to put a time limit on living wills. It worries me a little that there is no time-limit provision in the bill. Things do change. There have been developments in medical treatments following medical and technological breakthroughs. Last night the member for Avon talked about a lady who during debate on the Northern Territory bill advocated strongly that she should be able to end her life. Then there was some sort of medical breakthrough with her condition and she changed her mind and went on to live. We must bear that situation in mind and impose a time limit on living wills. That is one aspect of the legislation that concerns me a little.

A comment has been expressed by many members that the bill needs to be tightened in some areas. I agree with the member for Avon that the bill should be referred to a legislation committee so that it might investigate, clarify and perhaps iron out, to whatever extent it can, some of the flaws or perceived flaws and doubts surrounding the bill. I do not believe a legislation committee could ever get it completely right. Although the member for Cottesloe did not agree with what the member for Avon said about referring it to a committee, I think it should be referred to a committee. However, if it is not referred to a committee, at the very least plenty of time should be given to members to further consider the bill and hear a full debate on it, including what the minister has to say after members have spoken, before we vote on the bill.

Overall I support the bill. I definitely support the intent of the bill. I do have some reservations that should be taken into account and I look forward to hearing the minister's reply on this bill.

**DR J.M. EDWARDS (Maylands)** [12.24 pm]: I am delighted to speak on this bill. I welcome it into the Parliament and I congratulate all members who have made a contribution to the second reading debate. We have heard some really moving tales. Everything we have heard underpins the fact that this is a difficult bill and that members must have a conscience vote on it. The bill raises issues about death and dying, in particular about dying with dignity. There is no doubt that people do not want to think about their own death. There is a fair bit of reluctance in the community to talk about dying, so these are very difficult issues to try to wrap up and put in a bill that comes into the Parliament.

One very interesting aspect of this debate is the outline members have given of their decision-making approach to the bill. We have heard many different descriptions of the issues members have gone through and the questions they have asked in coming to their conclusions on whether or not they support the bill. For my part -

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and I will make my comments very brief - there is no doubt that my experiences as a doctor have influenced what I am about to say. However, like every other member of this place, I bring into this place my own life experiences; my own thoughts about the death in the future of my parents, other family members and me; and, obviously, my own values.

Starting with my experiences as a doctor, I must say first of all that these experiences were a long time ago and that I welcome all the changes in medical practice that have occurred since that time. However, as a very young doctor, I graphically recall being called in the middle of the night to give someone a very large dose of morphine and ultimately refusing to give it because I was worried that it would kill the person. I therefore had to call in a registrar, who was exceedingly nice and understanding about it and who explained to me that it would not kill the person because he had a condition - not pain - to do with his breathing and that he could now tolerate an extremely high dose of morphine. Together, therefore, we administered that drug and looked at the impact, and I was absolutely convinced that it was the right thing to do. It was the right thing in two regards. It was the right thing to question the dose and it was the right thing to help alleviate the person's suffering. Doctors, therefore, do worry about the decisions that have to be made in these areas. Young doctors in particular worry about the risks of the treatment they administer, even when they know that the treatment is in a patient's best interest. Most medical training is about prolonging life, saving life and keeping life going, which presents dilemmas for both doctors and patients.

Similarly, a long time ago as a young doctor, it was my personal medical experience that people were not good at telling others that they were going to die; in fact, in my experience they were not even very good at telling them the diagnosis. On a number of occasions it fell to me as the most junior doctor in attendance - the least experienced and youngest person, with no life experience - to tell people that they had cancer and that they would be dying. I am therefore grateful for all the changes in medicine that have occurred since then - the changes in communication, the advances in patients' rights and the fantastic services now, particularly in hospices. However, we must have all that communication, and this bill will serve a valuable role in getting people to think and talk about these issues.

I have also been party to other medical practices when at times I worried about what I was doing. I vividly recall one occasion when I was called to a patient I had never seen before in the nursing home part of a hospital. She was clearly distressed with her breathing, even though her conscious state was poor and her awareness of what was going on around her was not high. I conducted a thorough examination and assessment of that woman, made a diagnosis of a chest infection and, in fact, started her on antibiotics. I was then severely berated by her family for treating her because they felt that her mental state was poor and that she should just be allowed to die. To this day I remain comfortable with what I did, although I guess I questioned whether I was treating her or my anxiety for this poor woman's gasping for breath. There is no doubt that after a couple of doses of antibiotics she was much more comfortable. People need to talk about these issues. The member for Wagin said that children need to discuss with their parents and we, as members, need to discuss with our family members what they would do in those circumstances and what their expectations would be. People must have clarity about how they want to be treated towards the end of their life. In my experience the greatest worry that people have as potential or current patients is their capacity to stop treatment.

I, and I am sure other members, have heard people ponder after the death of a loved one whether that loved one needed that last operation, intervention or treatment. Perhaps that is a pressure that relatives and those around the bedside feel more than the patient. To have this kind of clarity enables decisions to be made and the person who is the recipient of the treatment to be much more empowered. These are difficult situations and it is better to have thought them through rather than have to think the situation through when it is a crisis.

If this issue is not difficult enough, it is confounded further by the issue of values and how we assess quality of life. A few years ago I was amazed to read in a rather prestigious medical journal an article about evaluating the quality of life. It was an interesting study that started out from a health economics point of view and it determined that the values underpinned by this study were critical. The study involved doctors and people with disabilities evaluating their quality of life. It was surprising that the doctors rated the quality of life as very poor and the people with disabilities rated the quality of life as very high. That should not have surprised me to the extent it did. As we look around the community there are people who live with all sorts of hardships and under great duress, but they find a quality of life that they appreciate. We need to be very aware that all these decisions are value laden and, at the end of the day, the reason that this bill is so good is that it empowers the people who are the subject of these decisions. It causes them to think about their quality of their life, their values and the treatment they want at a time when they are not in a pressure cooker or crisis situation.

I recall the case of an elderly relative of mine who literally appeared to be fading away before our eyes. He slowed down physically and mentally; he was quite old. People thought that that would be the way he would go out. In his case he had very bad anaemia that had not been diagnosed and, ultimately, he was found to be

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bleeding from bowel cancer. Even some of the doctors were saying that he was old and that his condition would involve major surgery. He had the surgery, transfusion and fairly conservative care and his quality of life skyrocketed and his mental state improved. It was a really good intervention.

In considering this issue, we must be aware that everyone comes to the table with their own values and, at the end of the day, it is what the person wants that is important. In my fairly limited experience of dealing with people who are dying, a number of people really do not want to die. Equally, a number of them, as was described eloquently by the member for Joondalup last night, pass away very quickly once they make the decision that they are ready to die. It comes back to the individual being empowered, and this bill will give people the capacity to be much more empowered to make these decisions.

The bill clarifies the situation for doctors and helps families discuss the issues. I will comment briefly on the advance health directives and the enduring powers of guardianship. We have heard a lot of discussion about the advance health directives. This bill applies to people over 18 years who have full legal capacity and can make advance treatment decisions and determine how they want that treatment to be managed. This bill also provides the capacity for a person to appoint enduring powers of guardianship, but that must be done in writing, and there is reference to the statutory form and regulations. Enduring powers of guardianship are not new. I understand that a similar situation has prevailed in California since the early 1970s. My research led me to Canada and I found that British Columbia has an act that is broader than this legislation that came into effect in 2000. One feature of that act that is different from this bill is that living wills need to be registered by a registrar, although there is provision for a proxy in the event that in the patient's best interests the living will needs to come into effect before registration has been able to occur. I was interested to learn that in Saskatchewan and Manitoba people who are 16 years or older are presumed to have the capacity to make these directives. I am much more comfortable with 18 years. In Quebec there is a mandate in anticipation of incapacity, which is spelt out quite well. It is similar to this bill, except that in Quebec it can be drafted by a notary. If people do not want to go down that path, it must be drawn up in the presence of two disinterested witnesses.

The Mayo Clinic's web site gives advice on how to go about making these important decisions. It spells out what are living wills and enduring powers of guardianship. It gives the benefits as well as the limitations of a living will. It does the same for a medical power of attorney. It outlines very clearly that people need to talk to their loved ones about these issues and that there must be strong communication. The ideas on the Mayo Clinic web site are issues that people need to take into consideration. They must look at the limitations and the benefits of what they are proposing. They must also think very carefully about who they will choose as their decision maker and make sure that they are comfortable with and trust that person. The web site discusses treatments. It lists treatments, for example, following cardiopulmonary resuscitation and describes what is known as the breathing machine. It lists when treatments can be used and, again, it goes into the benefits and limitations. It also outlines in one sentence on each occasion what would happen if a particular treatment was not used. This is information that people need to have and it is a valuable web site that will help them to think about these issues and come to their own decisions.

I have in my possession the living will of my research officer. I have her permission to have it incorporated into *Hansard*. It is the living will of Fiona Margaret Sassenfeld who, at the time it was made, was living in Rhode Island in the United States of America. The relevant part reads -

If at any time I should have an incurable or irreversible condition that, without the administration of life-sustaining procedures, will cause my death in a relatively short time, and I am unable to make decisions regarding my medical treatment, I direct that life-sustaining procedures be withheld and withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to keep me comfortable and to relieve pain.

It goes on to outline what procedures are involved. Further on it states -

I expressly authorize the withholding and withdrawal of artificially provided food, water, and other nourishment and fluids.

It is an interesting document because it had to be witnessed by two people. The document goes through statements by the witnesses and how they witnessed the document and it indicates that they are not related and do not have any interest in the will of this person. In fact, these documents were signed by a lieutenant in the navy and a legal officer.

The second part of the document is the statutory form for a durable power of attorney. The beginning of that part outlines what the form means and who should witness it. It is in the second part that Fiona Sassenfeld gives enduring power of attorney to her husband Kurt Sassenfeld. The document goes through the types of decisions that he can make and is witnessed by the same people. Interestingly, the document had to be lodged before a Rhode Island notary public and receive the notary public's official seal. To my mind, Fiona Sassenfeld's will is

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a good example of a living will. It was made by a woman in consultation with her family and after much discussion. It was witnessed by independent people, one of whom was experienced with the law. It was checked and given formal official capacity by being stamped by the notary.

I looked up the Rhode Island web site and was able to find very easily the act that governs this particular living will and also the regulations and other principles that are involved. I was easily able to track the legislation and see what thinking was involved.

I conclude my remarks by saying that the Acts Amendment (Advance Health Care Planning) Bill is good legislation. It is a big advance to have a bill like this introduced into Parliament. There is a need for this type of legislation because it will get people thinking and communicating with their relatives about their wishes. A secondary benefit is the protection it will give to medical practitioners who are involved in this type of care. The best thing I learnt from researching this issue is how fantastic some of the carers are who look after dying people.

Valid questions have been asked by members during the second reading debate. I very much look forward to listening to the Minister for Health answer those questions because they must be answered. If I were to make a helpful comment, it would be that people should talk to their health care providers or medical practitioners about what they think they might receive and what it is that they fear. Sometimes people fear a loss of dignity without recognising that the practitioners involved understand how people feel about maintaining their dignity and that they want to help preserve it. Sometimes interventions change over time and can give people better outcomes than could have been predicted.

**Dr K.D. Hames:** The living will you referred to sounds great. Indeed, it sounds like the type of will I would want to make. I want to know your opinion as a doctor about my concern that someone aged 18 can make a health directive about being unconscious and then try to commit suicide. What would happen to someone whose health directive prevented doctors from treating him after he accidentally fell over during a fight? Is that covered in the bill?

[Member's time extended.]

**Dr J.M. EDWARDS:** I have pondered the questions asked by the member for Dawesville. I would be worried if the bill left that open and that is why I am looking forward to hearing the Minister for Health's response. I believe that that issue is addressed in Fiona Sassenfeld's living will because it reads, "If at any time I should have an incurable or irreversible condition". That eventuality is covered in her living will, which is why I think it is a good example of a living will. Rhode Island, a very small state in America, has somehow got it right.

Another good thing about the Rhode Island legislation, which is easily seen on the Internet, is the chapter that outlines the health care power of attorney and some of the principles and general provisions involved. That chapter makes it clear that it does not condone, authorise or approve mercy killings or euthanasia. Again, that is a well-spelt-out level of protection in the context of this document.

This is one of the most difficult areas that people have to deal with. Dying is a very difficult subject to face. Indeed, it is a subject we all avoid. I congratulate members for the mature approach they have taken towards this bill. Debating such a bill in the Western Australian Parliament is a great step forward.

**DR E. CONSTABLE (Churchlands)** [12.45 pm]: I debated whether I would speak at this stage. The member for Dawesville's interjection made up my mind that I will make a contribution to the second reading debate.

In 1995 this house debated the Medical Care of the Dying Bill, which was a private member's bill sponsored by Hon Ian Taylor. That bill - I remember the debate clearly - enjoyed overwhelming support because of its content and importance. At the end of the day it was defeated by the government. The minister at the time, Hon Kevin Prince, said that although he supported the sentiments of the bill he would introduce his own bill. Here we are 11 years later debating this issue again. The Court government did not deal with this issue. It is an important issue that must be dealt with. I commend the minister and the government for introducing this bill.

The Taylor bill was aimed at protecting the medical profession and other health workers. Generally speaking, it accepted the medical practices at the time for those who were dying. It was equally about palliative care. That was the thrust of the bill. It was a good bill for its time. The bill now before the house takes up those issues but goes further than that. There are two major differences between the current bill and the one introduced by Hon Ian Taylor. The first is the advance health directives, which deal with not only the management of terminal illness, but also other adverse health and medical events. A lot of questions raised by members relate to that area. Like many other members, I will support the passage of the bill through the second reading stage. However, I want certain questions answered in the consideration in detail stage.

Every day of the week people make decisions about their health care when they visit their doctor. This bill allows for people to record in writing their wishes should something happen in the future, particularly in the

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event of a terminal illness. I do not think anyone disagrees too violently with people preparing for terminal illness and with being involved in that decision. The bill goes further than that and allows a person to record his or her wishes for other health events. That is where I think we need a lot of discussion and explanation.

The question has been raised whether those making an advance health directive will be well informed. I certainly support the suggestion made by the member for Swan Hills that at least one of the witnesses should be a doctor so that there is some certainty that the person is well informed when he or she makes a directive. An example has been given of a person who signs a health directive while aged in his 20s or 30s only to find that it is out of date in, say, 10 years, because of the sorts of advances that are now being made in medicine. I support the notion that directives should be renewed at regular intervals so that they keep up with medical advances and allow a person to rethink his or her circumstances.

I feel a sense of caution about this issue. I was not going to draw on a personal experience until the member for Dawesville interjected a moment ago. I know from what I experienced with one of my sons that some circumstances are absolutely impossible to predict and would be difficult to anticipate in an advance health directive. My youngest son was critically injured in a sporting accident at the age of 18. He was admitted to hospital unconscious. We were told after he had surgery by the very experienced doctors who were caring for him that they were not sure whether he would survive. Not only did he survive, but also only nine and a half weeks later he was back at university. Today, people would not know that he had had an accident. He has never been back to a doctor, and I do not think he has had a headache since. That was the first thing we were told. Two days after his first operation we were told that he had survived, but the medical people did not know how well. The next day he was reoperated on because things went backwards. It was the most remarkable case. If someone is able to put in a directive stating, "If I am taken to hospital after an accident and I am unconscious, I don't want treatment", I cannot support that, because having sat in an intensive care ward for nearly four weeks, I know what doctors and nurses do and I know what can happen. People can get good results. Of course, others may not be quite as fortunate as we were and our son was. However, I still find it very difficult to think that someone could say that in a directive when the circumstances are really not known. That is one area on which I want to hear quite a lot of discussion.

I support the suggestion that advance health directives should be renewed at regular intervals. I am also particularly concerned to be assured that health care workers, in particular nurses and doctors, will be protected by this legislation, given that these advance health directives are in the legislation.

The important part of this debate will be in the consideration in detail. I am very pleased that there will be a short delay - until next week perhaps - before we start that stage of the debate. I certainly do not support sending this bill to a legislation committee. The vast majority of members have spoken on this bill. I believe that all of us who have spoken, and others also, would want to have the opportunity to be involved in the next stage of the debate. Having said that, I look forward to the consideration in detail, because I hope it will clarify some aspects of the bill for me, and maybe there will also be some amendments as we work our way through the bill.

**MR P.B. WATSON (Albany - Parliamentary Secretary)** [12.51 pm]: I also congratulate all the speakers on both sides of the house. I was not going to speak in the debate on the Acts Amendment (Advance Health Care Planning) Bill 2006 because I did not get much feedback from my electorate. However, after hearing the various comments from members on both sides of the house, I thought I should make a contribution.

This legislation will give people the opportunity to make their own decisions. Other members have spoken about their families. Both my mum and dad died in not the nicest sort of way. My dad had prostate cancer and died a horrible death. I am sure that if my dad had had the opportunity to sign one of these directives 10 years before he died, he would have done so. Instead, we had all the drugs and so on administered to him, maybe to make us feel better. We wanted to think that our dad would be around forever, but maybe we did not take into consideration that it was time for him to go and that he did not want to put up with all the suffering. We saw what he went through. The situation was the same with my mother. She went into hospital for a single bypass, but she finished up having a triple bypass. She spent three weeks in intensive care, and I saw the suffering that she went through in those three weeks. She passed away after that. She was kept alive only by machines and drugs.

There is one issue that concerns me. It is a shame that the member for Dawesville is not in the chamber, because he raised the question of 18-year-olds. When I was out walking this morning, I was thinking about 18-year-olds. They can go to war and they can vote, and they will also be given the opportunity to take advantage of the provisions of this legislation. That concerns me. When I was 18 years of age, I always had the feeling that I would never make 30. Some people probably wish that I had not! When people are young, they have funny thoughts in their heads. If there are to be age groups, those people who are under 30 should be given the opportunity to renew their directives every five years or something like that. When people are 18, they do not

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have any responsibilities at all. They say, "If anything happens to me, turn off the machine. Don't worry about it. I'll be all right." However, by the time they reach 30, they have perhaps got a couple of young children, and they want to stay alive as long as they can.

I was thinking of another thing this morning. I am a Collingwood Football Club supporter. I would hate to think that I would sign one of these directives, and the machine keeping me alive would be turned off the day before Collingwood won the grand final.

Several members interjected.

**Mr P.B. WATSON:** I thought I might get some feedback on that. We just do not know what will happen. These days doctors can do tremendous things. Take, for example, my colleague the member for Mindarie. In his situation, he probably would not have survived five years ago.

**Mr J.R. Quigley:** Two.

**Mr P.B. WATSON:** Two years ago he would not have survived. If he had signed something like an advance health directive, the medical people might have turned off the equipment keeping him alive. Look at him today. He is a new father-to-be.

**Mr C.J. Barnett:** What is the point you're making?

**Mr P.B. WATSON:** I am just saying that the member for Mindarie may have signed something like that without realising what would happen and the treatment that would be available. However, I am not saying that that makes the member for Mindarie any more virile or anything like that.

When we were briefed by Doug Bridge, the palliative care physician, he said that dying is normal - I think the member for Wanneroo said that - dying is misunderstood and dying is the most profound life experience. We are all going to die. We all sit here today and think that we are indestructible, but we are not.

Under this legislation people will have an option. It is the same as men going for prostate cancer checks or women going for breast cancer checks. People have an option. If we pass this bill, people will have the option to make a decision. In today's society, people must be able to make their own decisions. As I said, I have some concerns about the age group. I was very interested to read a copy of the will from the United States that the member for Maylands had. It was very well written. In consideration in detail, I will be very interested in hearing what members say about writing these wills and who will be able to sign them. The member for Churchlands said that it should be a doctor. I do not know whether a doctor is the type of person who should be able to sign something regarding what will happen in the future. It depends on a person's religion. For instance, it could be a priest or a minister. As has been said in the house before, three 18-year-olds could get together and say that they are going to go out and do whatever. I mentioned that to the minister yesterday. He said that there are some 45-year-olds around who would probably do those sorts of things too. We cannot protect people in legislation. However, the 18-year-olds do worry me. I will have some input into the consideration in detail. However, all in all, I congratulate the minister on bringing this bill forward, and I will support it.

**DR S.C. THOMAS (Capel)** [12.57 pm]: I join everybody else in congratulating members on both sides of Parliament on the forthright and fruitful way in which they have conducted this debate. It is probably a pity that we do not do it more often, I suspect. It is an interesting debate. It has been quite an emotional time for a number of members. Obviously, that has had a run in today's paper. It is okay to be emotional in these debates. The member for Swan Hills got a bit of a run in the paper today. Of course, the press was not aware that I would probably have a tear in my eye too if the Minister for Health were to come and sit next to me. He is the onion of the Labor Party. That might bring a tear to my eye. He is very onion-like - multilayered, and all of them bring a person to tears. I believe that would bring a tear to everybody's eye.

I will make a couple of comments on the Acts Amendment (Advance Health Care Planning) Bill 2006. There has been a lot of talk about sending the bill to a committee. There are a couple of options, of course. I am sure that the Speaker or the Clerk will correct me if I am wrong, but standing order 183 allows the minister, or someone on his behalf, to send the bill to a legislation committee of five to 11 people, with representation from both sides of the house. Members might like the look of that. However, I suspect that if the minister feels that he has generalised support for this bill, he will not go down that path. Under standing order 171, the Legislative Assembly has the ability, in its own right, to send the bill to a committee. That would be one of the standing committees or a joint committee. Maybe a motion to that effect will be moved. It could be moved at any time during consideration in detail, if that is the will of the Parliament. I understand the arguments of various members that sending the legislation to a committee will involve fewer people, not more people. I suspect that this legislation is not perfectly drafted at the moment. A committee might be able to finalise and streamline the drafting process. My understanding of the comments of a number of speakers from both sides of the chamber is that there is general acceptance of, and support for, the intent of the minister and this legislation, but that there is

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a large degree of concern about whether the legislation as presented will deliver that intent. We might be able to address those concerns during the consideration in detail stage, but I suspect that that might be a relatively ad hoc and messy procedure. We might end up with second-rate legislation, because there has not been sufficient time to consider it, sort it out and come up with a piece of legislation that everybody supports. It is not my intention to move such a motion at this stage. However, like many other members, I will support the second reading of the bill to get the debate out in the open, if nothing else. The Parliament should not be afraid of any debate. It should not be afraid to tackle any issues, whether they be considered on the moral high ground or within the purview of the churches or the federal government. All those issues should be debated fully and frankly in this house, and it is appropriate that they be debated. Members' final positions on this legislation might be determined by debate during the consideration in detail stage, the acceptance of the title of the bill and the third reading debate.

A number of members have talked about specific cases of elderly relatives and other people, and about the personal interactions they might have had with legislation of this type. I will take a step back and look at it in more general terms and on a more philosophical basis. This legislation is approaching a dangerous area; that is, the debate about self-determination versus protection. That is the crux of the intent of this bill: the right to self-determine an outcome - in this case, effectively one's life - versus the protection of people in particular circumstances. This is an ongoing debate. It is not one that we have a general rule for. In fact, at both a state and federal level over a long period there has been a reduction in the ability and right to self-determine. I could give a number of examples.

Members will be aware of the probate system, whereby the directions in a person's will may not necessarily be complied with in the final outcome. There are numerous ways in which a will can be changed. In many cases the state itself will decide to replace the wishes expressed in the will with a completely different set of circumstances. For example, if a parent has a child who he thinks is beyond redemption and does not provide for the child in his will, the child is able to challenge the will and have the expressed wishes overturned. The person's self-determination could be removed by a court. I am intrigued to know what the Minister for Health proposes about the level at which the State Administrative Tribunal can intercede. That is a huge problem with probate. On a number of occasions this legislation states that the people who the State Administrative Tribunal deems to have an interest will be able to do a certain number of things. That could be a large group of people. There is potential for this legislation to include a large number of people, and that would thwart the intent of this bill, which most members support, which is to allow a degree of self-determination. If we take that argument to the nth degree, there is a possibility that 20 or 30 years down the track, a person's self-determination for his final hours, weeks, months or, in some circumstances, longer may be impacted upon by a tribunal or court.

This is a very difficult process to get a handle on. At the moment it is a very ad hoc system. A number of members have spoken about how the system works at a very ad hoc level. I agree with the members with a medical background who have suggested that this legislation will leave doctors, medical professionals, hospitals and, by definition, the state at risk because the ad hoc method will offer no legal protection. I agree that that issue needs to be addressed, and I am not sure that the legislation encompasses it. It certainly offers more protection to the medical profession. Does it extend beyond that to carers? That is an issue for members to debate during the consideration in detail stage. It might be that in proposing to encompass a large number of people, the minister will interfere with the process. The court might make the final decision for a person, or it could certainly have an influence on it. Although the minister wants to protect the system that will be put in place, I am not convinced that this legislation will achieve what it is intended to achieve.

There is a continuing issue of self-determination versus protection. I have occasionally expressed in the house a theological bent, and I will drift a little along those lines. A theological bent is generally based on a person's own opinion. It is not a piece of science that can be proved or disproved at any particular stage. However, the theological question is whether humans should or should not be able to make a self-determination. If we drag this back to a religious argument, I think we will have failed in the process. Freedom of choice is expressed in the genesis of my religion and in most religions in Australia, and particularly the dominant ones. Even if we go back to the plucking of the forbidden fruit, we find that freedom of choice has always been a component. If we get down to a religious argument that freedom of choice should be removed completely and that a person should not have freedom of choice about the termination of his life, I think we shall be lost and shall be dealing with theological dogma rather than the practicalities of an outcome that supports people. I do not think this is a theological debate, and I do not think this is a church debate. It is a debate based on whether the principle of self-determination in particular circumstances can override the principle of the protection of people.

As I have said, we have done the reverse. Of course we have laws to protect people from other people. That is essential and obvious. However, we also have a lot of laws to protect people from themselves. Over a number of decades we have developed a system in which people need to be protected from themselves. People must

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wear seatbelts. Rarely would a person's not wearing a seatbelt result in injury to somebody else. The person might fly through the windscreen and hit somebody, but that almost never happens. Seatbelts protect people. People regularly make a self-determination about whether they will or will not wear seatbelts. Generally, the Parliament legislates to protect people rather than to allow them to self-determine. I could give a number of examples in which the ability to make a self-determination is removed. It is a very brave piece of legislation that changes the trend from protection to self-determination. It would be very difficult to interpret. I am sure that there will be court challenges based on this legislation. How do we protect people from themselves? That does not mean that the Assembly should not address or debate the issue and, in the end, even legislate for it. I urge members to be aware that it will be a major change.

Members have talked about what may or may not be included in a living will that will define how a person is to be treated in the future. I agree that this is a relatively dangerous component of the legislation. Unless a thousand different medical procedures were listed, it could be very difficult. I am keen for the outcome of this process to be silent on areas that are not listed in a person's living will. If we embark on this process, it will be incumbent upon us to include in the legislation all those things that could specifically be listed in a living will. For example, the member for Ballajura could not have a living will that stated that should he be in a permanently comatose condition, he would not want medical treatment to be administered. It could go down all the way to whether a person has a hangnail and whether he should be treated or refused medical treatment. It would be very complex and messy. A person might list 999 conditions but miss one. He might miss the condition that he comes into hospital with. What does the profession do? It is very complex and messy. I suspect that the answer to the problems of the list will be in its simplification. We need to simplify the process rather than make it more complex. A person could list 10 conditions, such as severe degenerative conditions or severe trauma with no likelihood of regaining consciousness, which are long term and permanent. However, if a person presented at hospital without one of those 10 conditions, he would be treated with the best of medical skills and technology. That might be the only way that we can progress this. If we do not, a person may be subject to other conditions that may be a problem.

One of the issues a lot of people have talked about is changing medical technology. It is having a huge impact. When transplants were first performed during the 1960s and 1970s, they added a few months of life to the average patient. They later added a few years of life. In some cases nobody knows the extent to which the procedure will extend a life. At this stage it is an open-ended situation. Medical technology has changed enormously. We are talking about people being fitted with artificial hearts until a donor heart becomes available. I suggest that it will not be long before artificial hearts become a permanent fixture, as technology continues to improve.

We have a problem in society, which may impinge upon Mr Acting Speaker (Mr G. Woodhams). I refer to the ageing population. However, it is not exactly an ageing population because, generally speaking, there is a huge blip among baby boomers. There are a huge number of baby boomers in Parliament. I will tiptoe very carefully as Mr Acting Speaker may be a baby boomer. The baby boomer generation finished in about 1963. There are few of us who are not baby boomers. The member for Victoria Park is not one. There is no rapidly increasing population of elderly people; there is a blip in which the baby boomers are moving forward in age. There is a massive increase in technology, which will rapidly advance. Replacement surgery for hips and elbows etc is commonplace today. The situation is interesting because if medical technology improves too much and all the baby boomers start to live to 120 or 130 that might bankrupt the state, the country or most of the world. The growth in medical technology is a double-edged sword. Baby boomers could live for a long time. I am not sure that we can afford that.

**Mr R.F. Johnson:** I am one of them!

**Dr S.C. THOMAS:** There are lots of baby boomers in the house. The changing technology will have a huge impact. "Intergenerational warfare" is the current term. It is not grim but there is something of a conflict. This sort of stuff will have an impact. It is interesting to note, when looking at the demographics, that the baby boomers are the generation that is most likely to want to predetermine outcomes in their old age. In my role as chairman of the south west community health forum, I spent about a decade doing lots of health demographics. It is the baby boomers who are trying to make these decisions. It is appropriate that the baby boomers are introducing this legislation.

**Mr R.F. Johnson:** The minister is much older than a baby boomer!

**Dr S.C. THOMAS:** That is a little unkind although I know that I called him an onion earlier! We have a massive issue with changing technology, which will impact on the conditions people shortlist in relation to their future health care. Simplification will be the key. There are enormous dangers in this legislation. Lots of members have spoken about the suicide component. There is no legislative change that will have a dramatic



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impact on suicide rates; it is a completely different issue. It is a very interesting one. I do not think that we should involve ourselves too much in trying to impact on suicide with this legislation. I would love to debate at a different time the impacts on suicide, and how we might change them. There is a general feeling that the philosophy and intent behind this legislation is self-determination. I applaud the government for including self-determination. It has been my feeling that my side of politics is more inclined to support self-determination, and the minister's side is more likely to look at strongly protectionist models. It is good that we are finding some middle ground on this. That is a very positive sign. When we swap sides very soon, we know we will be relatively close together! That will be a good thing.

**Mr J.B. D'Orazio** interjected.

**Dr S.C. THOMAS:** It is just a matter of time, member for Ballajura. It is just a matter of looking at the stopwatch!

The theory of self-determination is very good. However, the delivery will be very difficult. I want to see the debate go forward and get into the technicalities of it. It sounds very simple to self-determine. In practice, the provision will be very difficult and dangerous. Those concerns are not theological, but they are the ones that we need to address very carefully over the next few days.

**MR D.T. REDMAN (Stirling)** [1.17 pm]: I will make a short contribution to this debate. I have reflected somewhat on what members have said over the past day or so. This is the first time I have been involved with an issue that has a conscience vote. It is encouraging to hear debate coming from the heart. Too often, in the house, the debate comes from the head. That often makes things very spirited. A lot of debate on this issue is coming from the heart. Indeed, members are drawing from their own experiences and those of people who have raised concerns. It is a very interesting debate. The standard of debate reflects positively on members.

As the member for Stirling, I represent about 14 500 voters. I make every effort to draw on the views of my constituents. Often we cannot help but draw from our own experiences. Our conclusions cannot help but be defined and moulded by them. Two of my grandparents passed away relatively recently. One of them had a fall and stayed in her house overnight. I will not mention the state she was in. It meant that she had to be taken to hospital. It was not much later that she had to be dosed with morphine to deal with her pain. As a consequence of that, she passed away soon after. I have no doubt that administering morphine was the right thing to do, which was the decision made by the people looking after her at the time.

My grandfather, whom I have mentioned in this house before, died as a result of an accident on a farm. Being the bushman that he was, the last thing he would have wanted was to finish up in hospital in a state in which he was unable to do the thing he so cherished, which was to be on his farm. I am sure he would have supported the legislation the house is debating and the spirit of this bill. I also had an uncle who passed away from cancer. The same situation applied in which medication reached the point of bringing on death. I am sure that the decisions were right on those occasions, and I support them.

I took the opportunity in one of my newsletters to promote the discussion paper that the Minister for Health put out on behalf of the government. A number of people called and wanted to look at it. I sent out a lot of copies. I was encouraged by the number of people who took an interest in the discussion paper. I certainly strongly support the minister for adopting that as an option for getting people engaged in the debate. Although only a handful of people have responded with their views, all are supportive of the intent of the bill. I have received no strong views against the intent of the bill. I believe, therefore, in adopting the position of supporting the bill. However, I have some concerns with it, as do other members. In supporting the bill, I believe that I am putting forward not only my personal position but also the position of my electorate.

I took time this morning to read through *Hansard* to clarify the position of those speakers whom I did not hear yesterday and who support the intent of the bill. The member for Dawesville did not necessarily give me the impression in his speech that he supported the bill. The member for Maylands today cited an example of her electorate officer who had her own living will. The member for Maylands described it to the house. The member for Dawesville said that he supported the spirit of it and that if that is what was meant, he would have his own living will written in the same format. It really comes down to a question of dealing with some of the finer detail of the issues that people are raising. I do not think that too many people are against the intent of the bill, but I believe they share some concerns over the detail and where traps might appear in its enactment if issues do slip through our fingers and are missed. I also strongly respect the qualified comments made by a number of members of the house, particularly those from the medical profession and indeed some from the legal profession. A lot of qualified comment has come from the house, which has certainly assisted me in coming to a position on the issue.

Our difficulty arises when we try to put in writing, and hence into legislation, the objective that we are trying to achieve. It makes it really hard. Every time we try to put something in writing it is very hard, because we want

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to make sure it captures all the issues we need to capture. The minister has been making notes about the issues that members have raised. I am sure that his response will address some of those issues. I am also sure that some of the amendments that this house and the other place will put up will address issues and concerns. I might make the point that I do not support the bill going to a committee. I believe that this bill will be subject to the scrutiny of a great number of members of this house and the other place, drawing upon not only their collective wisdom and personal experiences but also the viewpoints that have been expressed in their various electorates. That will give this bill the level of scrutiny it deserves. Hopefully, we will get to a point at which the legislation becomes something very workable in the community.

Even when we have run through that process, as with other bills in this house, I do not think that every issue will have been resolved. When legislation has been assented to and enacted, events occasionally occur in the community that we have not catered for or raised as issues. That should not prevent us from having the debate and trying to put in place the spirit of this bill. Even if it means we examine amendments down the track, as we do with other legislation that goes through this house, it is a very real part of the checks and balances of the parliamentary process in this state that will bring us to a position at which we finish up with something very workable that supports the intent of the legislation.

It was very encouraging to hear in all the debate of other members the example of the living will that the member for Maylands raised. I certainly could not argue with it. I would love to have something like that in place for myself; indeed, I will be taking steps to have a living will and go through a number of processes. It would be my choice, if this bill passes both houses, to put something on paper that defines how I want to be treated, particularly in my later years. I will be making a very strong assessment of the person I will have as an enduring guardian and those who will be in authority when I am not in a position to make those decisions for myself. Other members have mentioned communication and the choices about those who might be in a position to have authority over the outcomes that someone might want to achieve when he is not in a position to make those decisions himself. I believe that people will need to take many steps beyond those the legislation can define. I must highlight the fact that it is still a matter of choice. Passing this legislation will not mean that people must have a living will. They can choose not to have a living will. However, those who would seek to take that path can take it and put something in writing that defines how they want to be treated in later life.

I will support the bill at this stage. I will certainly be listening very closely to consideration in detail and the ways of dealing with the various issues that members have raised. I believe the legislation is a move down the right path. I also believe, as I have mentioned, that this is the position of a substantial number of the people whom I represent and, indeed, is my personal position.

**MR M.P. MURRAY (Collie-Wellington - Parliamentary Secretary)** [1.27 pm]: My support for the bill is very similar to that of the member for Stirling. Although community debate about this matter has been ongoing, it has probably been more concerned with the area of euthanasia. I make it very clear that the two debates are not the same. This bill is not about euthanasia but making a living will whereby people can be directed in the future. People involved in family disputes have come into my office and said they are not sure which way to go. Those disputes split families down the middle, because they do not know what a family member would want in his or her last days. I believe the bill would enable people to give a clear indication of what they would like to happen, which would then stop such family disputes. I know of one such dispute in which a brother had a different position from a sister, and the father sat in the middle. Because they had been given no direction, the argument caused a hell of a blue. Had there been some direction, that trauma in that household might not have occurred. I support the bill because it might prevent that happening.

The message coming through the front door of my office is to support the bill but to urge caution. Many other members have raised issues of caution during the past couple of days. During the consideration in detail stage, we should debate amendments with great care and not think that each one is just another amendment. We must remind members that the vote is not along party lines but a free vote. It means that they will be able to have their say without breaching any practices in place in this house. I ask members to listen to the debate on every amendment and to discuss them in detail. We must make sure that the legislation that is passed will have enough weight to be carried out in the community with justification. I take heart from the part of the minister's press release that states that the laws will allow terminally ill people to die with dignity and to have their wishes respected by medical staff and family members. That is a great line and what the bill should be aimed at - nothing more and nothing less.

People should be aware that it will not be compulsory to make a living will. If people do not wish to make a living will, there will be no compulsion for them to write one. That in itself provides a freedom so that if people want to put their wishes on paper to give direction to family members and doctors, they can do so with the law behind them. Previously that has not been the case. There have been many cases in which people have made a statement about what they want but it has not been enforceable. In this case, people will be able to have their

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wishes enforced by law. I think that is a very important point. It is not compulsory to have one; however, like the previous speaker, I certainly will have one, because I have seen what happens when people do not have one. I have seen what happens when a split comes about as a result of people within one family having different beliefs. I hope this will make families much more comfortable, even if it runs against their own beliefs, and able to follow the beliefs of their father, brother, sister or mother. They will be able to follow the person's personal beliefs.

First, I personally support the bill. Second, from the electorate's point of view, I would say that the weight of feeling is in favour of the bill. I have received many emails expressing different views and I will not vote entirely according to my personal view; I will vote according to what the electorate is telling me, and that is to say, "Go forward, but go with care; check the amendments that come through; and listen to other people's views." We have seen some views emerge over the past couple of days that have certainly opened my eyes to a different aspect of the debate. I believe that the bill is something that is needed within our community. It is members' choice. In the main, I support the bill.

**MR P.W. ANDREWS (Southern River)** [1.32 pm]: It is becoming somewhat like a broken record being played in the house. It is clear that many members support the intent of the Acts Amendment (Advance Health Care Planning) Bill 2006 and will certainly support its second reading, but also that they emphasise the need for caution. I think, sometimes, that of all people on this side of the house, I am one of the most cautious. I am going to support this bill for the simple reason that, regardless of whether the bill is passed or not, decisions are made every day, in every hospital where there are people dying or people who are mentally incapable of making their wishes known. Decisions will be made regardless of what we decide in this place about this bill. Many members have used examples from their personal lives in talking about advance health directives. The one or two particular examples that influenced my support for this bill relate to dialysis. I will couch my comments in deliberately vague terms so that anyone reading this speech will not relate it to themselves. I am certainly not referring to myself, although my experience of this is at first hand.

Many people reaching the end stage of renal failure are quite aged. The person I am particularly thinking of is probably in his late 70s, but a very old late 70s - physically more like a person well into his 80s. This person is a permanent resident of Australia but who originally came from overseas. At some stage he possibly spoke English very well, but he seems to have fairly advanced dementia. He has therefore reverted to his first language. This person is on dialysis twice a week; possibly three times. He is on a hospital bed, and he must know where he is because he does not make any effort to get off the bed. I have, at times, seen him try to get off the dialysis machine. For him, the dialysis involves having two knitting needles stuffed up his arm twice a week. It is very, very painful. He is obviously in extreme discomfort because he moans all the way through the treatment. He keeps saying, "I go now. I go now." He is aware enough to know where he is and that he cannot get up. He is obviously aware of the pain. It hurts me to watch this because he is in such discomfort. He is not conscious of his family being there. When they bring him in and take him out, he does not seem to be conscious of their being there. In normal circumstances, a person at that stage would not go on dialysis. It is quite possible that he was a reasonably fit and healthy person as recently as 12 months ago, and then reached the end stage of renal failure and went on dialysis.

This leads me to the question: who made the decision that this person should be dialysed rather than letting nature take its course? It is quite possible that in normal circumstances the patient makes that decision. However, I am aware of the case of an 82-year-old who was a very well-known state sportsman and who had reached end stage. A discussion was held within the family and the question of dialysis was weighed up. What benefit would he get from dialysis? How much longer would he last without it? What would he go through? What would the end result be? I know that if I were in a situation in which I would have that quality of life and that level of awareness of what is going on around me, I would certainly not opt for dialysis. For someone who is pretty ill, I am reasonably fit. I get in for parliament; I enjoy the biff around the place; I have still got my hair and still got my teeth. Nevertheless, some days I do not like it; I hate it. To make the comparison between someone who is fit and healthy like me, and someone of that age and life expectancy, it has to be asked why anyone would opt for dialysis treatment in that situation.

I therefore believe in the health directive, if it is a situation in which a person is sufficiently mentally competent to say, "If I degenerate, I do not want to be dialysed any more", or "I do not want to be in that circumstance." What is the alternative? The alternative is the family having to make the decision. What a terrible decision that would be. In many circumstances the decision is possibly being made for the family. They cannot reach the point at which they let mum or dad go and therefore they place the person on dialysis. It is a much, much better system for the person to make the decision while he or she is in a fit mental state.

The second example that leads me to support the bill - people like the member for Dawesville and the member for Maylands have experienced this first hand - is what the Americans call the "daughter from California"

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syndrome. It is a situation in which all reasonable medical treatment has been performed on a person who is terminally ill; the person has reached the end stage and there is nothing more to be done except make the patient comfortable. All of a sudden the daughter from California storms in at the last moment and demands extraordinary measures be taken to extend the life of the patient by a few more hours or an extra day, because she has ignored the patients' illness during the whole time she has been away. I have seen examples of this at first hand. I do not like to use the expression. In that circumstance, a living will obviates the discomfort that is felt within the family and by the medical professionals who are there.

Many times in a hospital setting there are arguments among family members, because although the next of kin is supposedly the person who should be making the decisions, that person is too stressed out to be making the decisions. I know of one example where the son's new girlfriend was the person who was dictating what should take place. In those sorts of circumstances, the concept of advance planning will obviate the need for another person to make the decisions that need to be made. Therefore, I agree with the proposed change to the priority of decision making. I also endorse the principle of appointing an enduring guardian. As I have said, at the moment the decisions tend to be left to the next of kin. Usually that is the spouse or de facto partner. However, in many circumstances the spouse or de facto partner is the last person whom we would want to make decisions on our behalf, because that person might be too emotionally involved. Also, that person might not have the training or education that would lead him or her to make the right decision. When people choose a person to be their enduring guardian, they will choose the person whom they think will do the best job. It is a bit like choosing a person to be the executor of our estate. I believe this proposed change to the priority of decision making will produce a better outcome for all concerned. We can all think of circumstances in which our partner or next of kin, or our son or daughter, or whoever might be in line to make decisions about our care, is in no position to do that. Therefore, people should be given the right to choose a person who will follow their wishes, and with whom they feel comfortable. That is certainly an important benefit of this bill.

I read in the paper this morning that this bill is a watered-down version of euthanasia. I cannot see that in the bill. However, I will be listening to the debate during consideration in detail, because I am interested to hear the opinion of other members and to see whether I can pick that out in the bill. I put on record that I do not support euthanasia as a matter of principle. I also do not support euthanasia as a matter of practicality. I cannot see how we can put into a bill that would allow euthanasia all the safeguards that would be necessary. I will not debate euthanasia today, because this is not the appropriate time and place. I have no hesitation in saying that as a pro-life member of Parliament, I do not support euthanasia. My view on that matter is well known. However, as I have said, I am willing to listen to other people's opinions.

Most members in this place support the intent of the bill. We support the second reading of the bill. However, we can think of a thousand what-ifs. I have heard some of the what-ifs. It is the what-ifs that worry me. The current situation is that a person who is ill can refuse medical treatment. However, it worries me that even when we make plans in advance, many variables can come into play. The member for Capel made a good point about how we can itemise 99 things that may happen, but we may miss one extra thing that may happen. I am not 100 per cent comfortable that we can cover all the what-ifs. I will give an example of a what-if. A person may have undergone a liver transplant procedure that he found so traumatic that if he had to make a choice between life and death - that is, going through that procedure again and living, or not going through that procedure again and dying - he would prefer death. That person may have written in his living will that if he loses consciousness, and even if a liver becomes available for transplantation, he does not want to undergo another liver transplant. A person certainly has the right to give such a directive. That situation exists currently. I will be interested to hear during consideration in detail about some of these thousand what-ifs. The member for Dawesville could probably come up with far more what-ifs than I ever could. It is very important that we support the principle of allowing people to determine their own health care, and to appoint a person to make those decisions on their behalf if they do not have the capacity to do so. However, we also need to be conscious of the fact that in giving people freedom of choice, things will never be perfect. I return to the point made by the member for Capel. We believe in individual choice in treatment. However, a person may choose to die even though there is a possibility that medical treatment will extend that person's life. To me that is morally wrong. However, should it also be legally wrong? That is the question that I ask myself, and that is the question that I want to have answered during consideration in detail.

The bottom line for me is that I support the bill. Decisions need to be made. I believe the health professionals are already very well protected. However, I will accept the word of people in this place who perhaps know the law better than I. I used to feel a little uncomfortable when I talked to people who had worked for Silver Chain and had provided palliative care for cancer patients to relieve their pain, and in the process the person had passed away. I think the days have gone when that was an issue. However, if members are telling me it is still an issue, then I believe this legislation will help to resolve that issue. If there are other issues on which the law is absent or vague, such as protecting health professionals who are acting with good intent, perhaps we should look at

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dealing with that in legislation as well. With those comments, I repeat that I support the bill. However, I exercise due caution with regard to the bill. I do not believe it is related to euthanasia, but I am prepared to listen to debate on that matter. I am certainly prepared to listen to any amendments.

**MR J.B. D'ORAZIO (Ballajura)** [1.47 pm]: This is only the second time since I have been in this Parliament that we have had a debate in which members have been able to put their views freely. That is very refreshing. It is good to hear the different views on the different sides of the Parliament. The Acts Amendment (Advance Health Care Planning) Bill has been a very troublesome bill for me. I come from an ethnic background. I am also a Catholic. When this bill was first talked about, I was vehemently opposed to it. I believe in the theory "if it ain't broke, why fix it?" Life-and-death decisions are made by doctors every day. When we attended the briefing on this bill, some of the doctors who are working in this area indicated that the passage of this legislation would not change the situation very much. They said that doctors would continue to do what they have been doing for a number of years; that is, work with the patient and try to keep the patient as comfortable as possible. From that point of view, I still maintain strongly that there is no need for this bill. Why do we need to legalise something that has been happening since the year dot? I then decided that I would take this bill to one of my branch meetings. That was a very interesting experience, because at this branch meeting there were a lot of ethnic people, mainly Italians. There were also a couple of English people. I have never heard a more vicious debate in all my public life. These people were absolutely vicious with each other. One lady recounted the story of how she had sat with her mother for nine months and watched her slowly die. This lady said that if there had been some way for her mother to have this sort of living will, it would have been a godsend. She related endless stories about her mother having no sense of where she was and no purpose. However, people on the other side of the debate were saying that there was no way we should do that; we should use every possible means to protect human life. That created a major dilemma for me because I had honestly thought that the view I had, which was not to change anything, should prevail.

**Dr K.D. Hames:** On which side was the Italian person in this debate?

**Mr J.B. D'ORAZIO:** The Italians held the strong Catholic view that there should be no such legislation, and that human life should be protected.

**Dr K.D. Hames:** I have known many Italians who have been in that situation with their own parents.

**Mr J.B. D'ORAZIO:** It is interesting that the member should say that, because one of the Italians quoted an example of his own mother who was in a vegetative state. At the time, the decision might have been made to withdraw life support but then, all of a sudden, she miraculously came back and lived for another seven years. They were saying that they would have hated to be in such a position. What made it worse was that they then went one step further and said that if a member of their family were to give to another family member the power to decide, that in itself would create a major problem. Other family members might say that they did not agree with that decision, but they would be unable to influence it, and that would create major problems in ethnic families. I pointed out that they did not have to have a living will; they did not have to take the opportunity of drawing up such a document, although it should be available to those who wish to do so. At that point I assumed that I would support some sort of legislation that would allow the opportunity to draw up a living will.

However, listening to the debate in the chamber, it has become apparent to me that people's life circumstances can change dramatically. The decision a person might make at the age of 18 might not be a decision that that person would like to make later in life. There would have to be some provision for a limited period, so that change can be accommodated. Being a pharmacist, I can relate the story of one of my long-time customers who, when he was in his mid-40s, said that he did not want to be a vegetable and that the quality of his life was very important. By the time he reached 70, he was using a walking stick and he could hardly walk, but he was saying that it was better to be alive than to be dead. All of a sudden, his life expectations had changed. We do not want a living will to be in place that could affect the outcome for a person who is not able to make a decision. It may not necessarily be that the person is physically incapable; he may not have the mental capacity to make that decision. I need to be reassured that there are some safeguards for such a circumstance.

The member for Southern River made the comment that there are a lot of what-ifs. If we are to make legislation that affects people's lives and their ability to keep on living, it is not acceptable to have what-ifs. Some protections are needed. That is why I am uncomfortable with the scenarios that have been put up by a number of members. I know that we should not talk about such things, but I go back to the case of my mother when she was dying. Being a pharmacist, I know that the dose of morphine she was getting was enormous. She was dying of cancer, and she was being given a dose sufficient to keep her relatively pain free. I have this enduring image of her passing away with a smile on her face, and it still makes me happy. It was still very difficult, and I would not have wanted to make the decision about what was to happen to her. Before my mother passed away, my brother tried all sorts of different treatments, from acupuncture to vegetable seeds, but nothing worked. He worked to the very last day trying to find some way of keeping her alive. That is the difficulty with this process.

Mr Terry Waldron; Dr Judy Edwards; Dr Elizabeth Constable; Mr Peter Watson; Dr Steve Thomas; Mr Terry Redman; Mr Mick Murray; Mr Paul Andrews; Mr John D'Orazio; Mr John Day

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There is also the danger that if a person has a right to make a decision and does not do so, someone else may make a different decision that would not otherwise be made. That also changes the process.

I am torn here. I would like to be able to give people the opportunity in those circumstances that are absolutely clear cut, but I do not want one single person falling through the net and having his or her life taken because of the inadequacies of this legislation. That is a really difficult decision. I am glad that we have a free vote on this bill, because I will be looking at each of the clauses very carefully in consideration in detail and considering all the amendments. I have a problem with passing legislation dealing with people's lives when there are what-ifs. I would not be supporting this legislation if I thought there were what-ifs that were not covered in some way. This legislation has some merits, as was pointed out to me by some of the people who have first-hand experience of dealing with people in a terminal stage, and had major dilemmas and problems. At the same time, I can see the other side of the equation; that is, we as parliamentarians legislating for the people need to make legislation for the lowest common denominator, and what-ifs, in my opinion, are unacceptable.

**Dr K.D. Hames:** Before you sit down, may I interject to place something on the record? I said that I would vote against the second reading because I have the same concerns you have. However, I think I might vote for the second reading and try to get those concerns dealt with during consideration in detail.

**Mr J.B. D'ORAZIO:** As I said, I am happy for the bill to go to the next stage, because I think that is important. However, I want to make sure that whatever we vote on at the end of the process protects everybody. I do not want to get this wrong; it is too important. We need to make sure that all the what-ifs are covered. I think the member's suggestion to let the bill go to the next stage is sensible, because we still have the right to vote against the bill in the third reading if we do not find it acceptable.

**MR J.H.D. DAY (Darling Range)** [1.57 pm]: Question time is fast approaching, but I will make a start on my contribution to this debate. The first point I make is that this issue has quite a long history in Western Australia and in this Parliament. The Law Reform Commission was asked in 1986 to review the legislation in Western Australia in relation to the issue now being covered by the Acts Amendment (Advance Health Care Planning) Bill 2006. In particular, the commission was asked to consider whether medical practitioners or others should be permitted or required to act upon directions by people who are severely ill and have previously expressed wishes not to have their lives artificially prolonged. The Law Reform Commission produced a discussion paper in 1988 and its final report and recommendations was published in February 1991. The background to the Law Reform Commission being asked to report and make recommendations on the issue was in a conflict in the legislation affecting this area in Western Australia. When I speak about legislation, I also refer to the common law situation. The situation existed, and still exists, in which on the one hand patients have rights not to be treated without their consent, while on the other hand there are obligations under the Criminal Code for people to perform acts whose omission would be dangerous to human life and health. There is a conflict between those two aspects of the legislation in Western Australia.

The recommendations of the Law Reform Commission were fourfold. First, it recommended that adult patients be able to complete a refusal of treatment certificate specifying that they do not wish to receive life-supporting treatment. Second, there was a recommendation that people should be able to appoint an agent in the form of an enduring power of attorney to make treatment decisions on their behalf. Third, there was a recommendation that the agent should be required to make decisions in the light of what the agent believed the patient would want as far as it was known, and that there should be the ability to take into account changed circumstances when it was appropriate. Fourth, there was a recommendation that doctors should not be civilly or criminally liable for administering drugs or other treatment for the purpose of controlling or eliminating pain and suffering. It is my understanding that in general terms those recommendations are the purpose of this bill.

Debate interrupted, pursuant to standing orders.

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