JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS REGARDING THEIR OWN END OF LIFE CHOICES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
FRIDAY, 9 MARCH 2018

SESSION THREE

Members

Ms A. Sanderson, MLA (Chair)
Hon Colin Holt, MLC (Deputy Chair)
Hon Robin Chapple, MLC
Hon Nick Goiran, MLC
Mr J.E. McGrath, MLA
Mr S.A. Millman, MLA
Hon Dr Sally Talbot, MLC
Mr R.R. Whitby, MLA

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Hearing commenced at 11.12 am

Reverend ASHLEY SAUNDERS
National Director, FamilyVoice Australia, examined:

The CHAIR: On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. I am Amber-Jade Sanderson, and I am the Chair of the joint select committee. Mr Simon Millman has had to leave this morning, and gives his apologies. We have with us Hon Dr Sally Talbot; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; Mr Reece Whitby; and Hon Robin Chapple. The purpose of today's hearing is to examine the current choices around end of life and to identify any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. I advise that the hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing. Before we start, do you have any questions about your attendance?

Rev. SAUNDERS: No.

The CHAIR: Before we begin with our questions, do you want to make a brief opening statement?

Rev. SAUNDERS: Yes, please. I am the national director of FamilyVoice Australia. That is an organisation that has supporters and branches in every state, including Western Australia. I was to be accompanied here today by our Western Australian state director, but he is presently undergoing treatment for a very serious illness, and he apologises. If our Western Australian branch chairman, Paul Connelly, arrives, he might be sitting up the back before I finish today. I have served as the national director of FamilyVoice Australia for 15 months. By way of background, I practiced as a solicitor in New South Wales for 19 years. During that period of time I also served in elected public office for six years, and then I became an ordained Baptist minister and served in that capacity for 16 years before taking on this current role.

FamilyVoice Australia is a Christian advocacy organisation. We believe in the inherent value and dignity of every human life from conception to its natural end, and we believe that that is a human dignity that is not dependent upon life circumstances. There is inherent value and dignity in every life. We therefore believe that public policy or laws should not sanction suicide, assisted suicide, assisted dying, euthanasia or other options that intentionally end a life. We take this position both objectively, based on the data that is available, but we also take that position filled with love and compassion. I trust that the contribution that I make today to this inquiry will be both given and received as a loving and compassionate contribution to your deliberations.

In terms of policy issues, our submission makes various observations and recommendations. We address the issue of the autonomy of the individual versus the common good, and we argue that the place of individual choice in such matters should always remain a secondary consideration to the primary consideration of the protection and the wellbeing of society at large, so that legislators must consider the effects of change upon the whole community as well as the unintended consequences upon other ill and vulnerable people, upon the practice of medicine and aged care as well as upon the broader community. At a time when elder abuse is starting to receive the attention it deserves, it is in my view not fanciful to suggest that if assisted suicide or euthanasia were lawful, so-called "inheritance impatience" or other abuse could extend to creating an environment where

a vulnerable person were to believe that he or she owed it to their family or to the wider society to end their life. This would become the ultimate elder abuse and, as the committee has heard already, the idea of the fear of being a burden is a significant reason for people seeking assisted suicide or euthanasia in those jurisdictions where it is permitted.

Let me tell you a story, if you would not mind. Almost exactly 40 years ago as a young clerk, I instructed counsel in a coronial inquest into the death of an elderly woman following knee replacement surgery at a hospital. The evidence given by a nurse was to the effect that after mum went back to the ward, her family members—sons and daughters—were in the room and they were arguing about who was not going to have mum when she comes out of hospital. Remember, this is 40 years ago. Anyway, the medical evidence was that after this incident in the hospital room mum became extremely difficult and became extremely uncooperative in terms of her rehabilitation. She developed a deep venous thrombosis in her knee which dislodged and became an embolism, and then when it blocked the pulmonary vein she died. The idea that she had—that she was a burden and she did not want to be a burden on her unloving family—even 40 years ago as a young law clerk, really stuck on me and I remember it very well.

It is not in my view fanciful to suggest that either assisted suicide or euthanasia could become the ultimate elder abuse, and we do not believe that there can ever be sufficient safeguards to protect vulnerable persons. As someone who myself has struggled with clinical depression, including having taken a year and a half off work to obtain treatment, can I say that to the extent that policy or law permits assisted suicide it sends to the community a very mixed message about suicide. Can I add that to the extent to which policy or law permits a doctor or other person to take a life it amounts to legally sanctioned killing, something which is foreign to our nation and rightly rejected by our medical bodies.

Can I tell another story? I have been touched by deep suffering, professionally, pastorally and personally. In terms of my personal experience, I have permission to testify about the wonderfully valuable lives that are led by my two male nephews, who were born with cystic fibrosis and were therefore born with a terminal illness.

I have their permission to testify to the amazing contributions that they make to the lives of others, despite their suffering. Not only do they grow through suffering, but those of us who are close to them also grow as we witness their growth, even though we have been brought to tears many times when they are very low in their health, when they have been close to death, or when they grieve deeply the death of lifelong friends. These are real issues. People, I guess, who would appear before you on both sides of the debate have been deeply touched by deep suffering. My final comment as an opening statement would therefore be to thank you for your careful deliberation, and I ask you to weigh the evidence carefully.

[11.20 am]

The CHAIR: Thank you. Can I ask, Reverend Saunders, do you think that palliative care is 100 per cent effective for everyone?

Rev. SAUNDERS: It can be effective. In our submission, we highlight some of the areas in which it can be improved, not only improved in terms of closing some of the gaps that even the Western Australian Department of Health recognises as exist here in this state, but also in terms of a proper understanding about what palliative care is—that palliative care is so much bigger and wider than mere alleviation of suffering. It is not as though palliative care relieves suffering and at the same time you cannot look after other issues. Palliative care, by the World Health Organization's definition, is something that attends to not only the physical but the psychological and the spiritual needs of the patient, and also in a sense brings in the family and friends of the loved one. So there

needs to be, in my view, a much bigger understanding of what palliative care is—that it is wider and broader than alleviation of pain or suffering. There needs to be proper education of the community through appropriate channels, including through medical surgeries and medical practices, about its availability. There needs to be excellent, I guess, funding and structural incorporation of palliative care not only in cities but in regional and rural areas, where again the Department of Health recognises some challenges or gaps.

Hon COLIN HOLT: Thanks for joining us. Are you based in New South Wales?

Rev. SAUNDERS: No. I presently live in Queensland. Our national office is in Adelaide. I work partly from home and partly from the national office, and because it is a national role I find myself occasionally in beautiful places like Perth.

Hon COLIN HOLT: Okay. This is relevant, I think, to what I am going to ask you, because one of your recommendations in your submission talks about a public education campaign around advance care directives. I have to say we have had evidence about the mixed views about advance health care directives in Western Australia, which would suggest to me that we may not have it quite right. One of your recommendations is to raise an education campaign around the use of them. I wonder what WA can learn from your experiences or your statement there in terms of how we might be able to change it for the better before we go and promote it?

Rev. SAUNDERS: I think it needs to be promoted. My experience is partially pastorally but mostly professionally as a lawyer. People do not want to be reminded of their mortality. For example, even as a lawyer, if husband and wife were coming in wanting to do their wills, it is invariably husband dragging wife in because wife does not want to face her mortality, or wife dragging husband in for the same reason. Not uncommonly, I got to the point where I needed to ensure that the will was drafted while they sat in the waiting room, rather than getting them to come back another day, because coming in once to be reminded of their mortality was enough and often we did not see them a second time. So there is that issue in terms of people in the community. I do believe that medical practices, faith communities and community centres and community groups can all play a part, as well as social services, in promoting them better and ensuring that there is a better understanding of what they are and what they are not, and what they can do and how good they can be.

Hon COLIN HOLT: I would agree with you. I wonder whether you are familiar with the Western Australian advance care directive and how we could improve that?

Rev. SAUNDERS: I can take that on notice. I do not have any personal direct understanding of how that could be improved, but I am more than happy to take that on notice to liaise with our fellow here in Perth and provide you with some suggestions.

Hon COLIN HOLT: Thank you. That would be good.

Hon NICK GOIRAN: Reverend Saunders, I have an interest in elder abuse, and in fact I chair a select committee into elder abuse. I was interested in your comment earlier that if assisted suicide were to be legalised in Western Australia, it might lead to the ultimate elder abuse. Earlier this week, the committee had the opportunity to go to Albany in the south of Western Australia and take evidence from individuals. I would invite your comment in respect to this evidence that was taken earlier in the week. One of the ladies who appeared before us and talked on this issue of elder abuse said that an elderly person experiencing elder abuse would feel disillusioned. I can certainly empathize with her comment that a person experiencing elder abuse would feel disillusioned. They went on to say that that person would therefore welcome an end of their life. That is quite a radical position in contrast to your own, but it is not one that I have never heard of before. In fact, I have heard at least

one parliamentary speech suggest that the lack of euthanasia in Australia is the ultimate elder abuse. So it is interesting that you would use the same language. I just invite your comment on that.

Rev. SAUNDERS: Certainly we take the view that public policy needs to be, if you like this language, undertaken in the cold hard light of day, that we need to objectively set policy that is objectively good for the community, and within that framework to ensure that there is provision for those people who are vulnerable. In terms of elder abuse, do I believe that somebody who is suffering elder abuse might be suicidal, if I use that language? The answer is yes. Does that mean that that person's wish or desire should be granted? My view, based on not only the data that is referred to in our submission, but also in terms of the understanding of the value of every human life, is that no public policy should every sanction suicide or the deliberate taking of one's life. I said in my opening statement that allowing assisted suicide sends a mixed message about suicide. We cannot see a report on television or even on our news feeds about somebody who they will not even tell us has committed suicide. We have got to read it between the lines, when the last entry says, "If you're struggling, you can ring Lifeline." We recognise that suicide is a major issue in Australia. We recognise that youth suicide is a major significant issue. We cannot afford to send mixed messages about the value of life or about suicide. So in a sense giving in to a person, whether older or younger, when they are for one reason or another suffering and desiring to end their life, in my view is bad policy and actually is counterproductive.

Hon NICK GOIRAN: Can I go to the issue of suicide. Reverend Saunders, yesterday we had the opportunity as a committee via Skype to interact with Dignitas from Switzerland, and some questions were asked on the issue of suicide and the extent to which suicide rates have changed in Switzerland since Dignitas has been in existence. I am paraphrasing the evidence here, but in essence the witnesses conceded that in Oregon, the suicide rate was worse, and they distinguished that from the Switzerland experience by saying that the Oregon legislation is too restrictive and that the Switzerland model allows for a far greater range of individuals to access assisted suicide, and as a result they say that there has been no impact on the suicide rate. In fact, I think they may have even said that it had improved. I just wonder whether your organisation has had any opportunity to look into this issue at all in Switzerland.

[11.30 am]

Rev. SAUNDERS: I am flicking through my notes. We do quote the Switzerland example in one case but I believe it is in a different area. As I have been flicking through, I cannot find it. Certainly, the research that we have done—it is included in our submission—indicates that at least in some jurisdictions, suicide rates where assisted suicide or euthanasia have been permitted have, at best, not got any better and, at worst, have declined. Certainly, that is a reference to some jurisdictions. It may be Switzerland that we quote but I cannot find the reference in that to our submission at the moment, but certainly our submission does refer to some jurisdictions where granting these kinds of laws does not improve the suicide rate.

The CHAIR: We have had a lot of strong evidence from individuals, in particular older people who are very much in support of the introduction of voluntary assisted dying. Obviously, we have seen the polls, if you like, which claim to have significant public support. Why do you think there is such public support?

Rev. SAUNDERS: We live in a society that increasingly worships youth, a society that increasingly shies away from the idea of pain and suffering. We live in a society that, in my view, does not actually see—I put these words as lovingly as I can—the value in suffering. From my personal experiences, professionally and personally, I have seen enormous value and contribution in and through suffering. But we live in a society that increasingly shies away from that almost like we are entitled

to be pain free. Please do not hear these comments as other than loving and compassionate. That is the nature of the society in which we live. There is also a fear of what dying means. There is not as much exposure to the reality of death as a part of life. There is fear of being a burden. In fact, in one of the US states, even those who support assisted dying indicate that a fear of being a burden is cited as a request for assistance in between 40 and 59 per cent of the occasions. In my view, there is a lack of understanding about the nature of palliative care. There is not very clear clarification about the goal of care, whether the goal of care is curative or palliation, and our submission makes some recommendations about that. It is about fear; it is about ignorance in some areas; and it is about the nature of the society in which we live that shies away from the reality of pain or suffering.

The CHAIR: I want to unpick that a little bit. Can you tell us what the value of suffering is?

Rev. SAUNDERS: At the expense of being thought to be too light-hearted, at a time when I was a young solicitor and my brother-in-law was killed in a work accident, his brother, my best friend, told me this poem that said —

I walked a mile with Pleasure;
She chatted all the way;
But left me none the wiser;
For all she had to say.
I walked a mile with Sorrow,
And ne'er a word said she;
But, oh! The things I learned from her,
When sorrow walked with me.

That was the testimony of my best friend whose brother had been killed in a work accident. I know that talks about sorrow but we can grow through suffering. As a pastor I have had the pleasure—the privilege I would say—of sitting for several days with an elderly lady who was dying. As we talked and as I allowed her to sleep and as we talked again, I observed enormous depth and insight in what she was telling me, and it was a privilege. So there are, in my view, objective and subjective reasons for seeing that we can grow through suffering.

I mentioned before the situation of my two nephews. In fact, the younger of those two nephews, when he was in his early twenties —

They are in their early thirties now and thank God, they are still alive. When they were born, their life expectancy was 16, but they are both now in their early thirties. They are both married and they both have children. When he was in his early twenties, he used to go to a youth camp put on by one of the Lions or Apex clubs for troubled youth. He would simply share something of his story. He was able through sharing his story to see these mostly boys just in tears when they realised in a sense how bad he had it compared to their own troubled experiences. There is enormous growth for the individual but also for those around them.

Mr J.E. McGRATH: Getting back to that person that you went and sat with over several days; she was obviously one of your parishioners.

Rev. SAUNDERS: If I can just cut in; she was not, but through a friend of hers, I was asked to see her.

Mr J.E. McGRATH: Would there be people out there in the community that may be, really religious people who were not part of a church parish and had the support of the parish, that would not have got that support that you gave that lady? Even though they are getting some form of palliative care, it might be a little bit different from having a person of the cloth or a minister of a church go and sit with that person.

Rev. SAUNDERS: The answer is there are too many people who are lonely in their illness and in their old age. As I said, this lady was not a member of our church, but I was asked by someone close to her to see her and she allowed me to sit with her. So I am thankful to both her and the friend of hers who invited me in. It is an enormous privilege to sit with someone who is dying and it is not one that I take for granted. There are too many people who are lonely and die alone. As you have already heard this morning, there are too many people who die in hospital when they want to die at home. We need an expansion of social services. My challenge to churches would be to look outside your building, not just inside. That would be a message to people of faith as well as non–faith based community services.

The CHAIR: Reverend, can you just help me to understand this concept of value of suffering for someone who is imminently about to die? What do they gain from suffering when they are imminently about to die?

Rev. SAUNDERS: I have seen some people, in a sense, if you take things that they have said before and things they are now saying or even things they said yesterday versus what they have said today; I have heard, I guess, an increasing depth of insight, an increasing depth of understanding. Even, if you like, I spoke before about, as a solicitor, where people were not willing to face their mortality. My experience sitting with people who are dying is that they come to a point where they accept their mortality and, despite the suffering and in accepting their mortality, there is an opportunity for what I would call spiritual growth, whether that is faith, a Christian spiritual growth or spiritual growth in the sense that it might be more widely understood these days. So the depth of insight, the change in the way that they view life and they view death—from my perspective I give thanks to God for that growth even in the last stages of life.

[11.40 am]

Hon NICK GOIRAN: I would like to ask a little bit about safeguards, Reverend Saunders. Surely it must be the case that in a compassionate society we would not want to see people suffering unnecessarily and against their choice, and so as a compassionate society we should legalise assisted suicide to give people access to that choice, but, of course, under the proviso that there would be strict safeguards. You are very categorical in your submission that safeguards are illusory. Why are you so categorical about that?

Rev. SAUNDERS: First of all can I say that love and compassion is not always characterised by giving somebody what they want or what they think they want. Love sets boundaries and compassion looks to the greater good. So I take issue with your premise that a compassionate society should legalise something which is in our submission and my evidence objectively not for the common good. In terms of safeguards, you are aware of the House of Lords which says there can never be adequate safeguards. One of the things that is argued by those like me who oppose assisted dying or euthanasia is that there is always the pressure to expand; that is commonly called the slippery slope argument. Even if the legislation does not change, we see, for example in the Netherlands, that the interpretation or understanding of the same legislation changes, so that without Parliament in the case of the Netherlands changing the law, the practice changes because the interpretation and understanding of the law changes. Based on that, based on, I guess from my perspective, the objection of the medical community, based on what amounts in my view to falsifying death certificates to overcome life insurance issues, based on that and so many other things that are in our submission, we take the view that there can never be enough safeguards.

There are some pretty convincing people—again, I have dealt with some mainly as a solicitor—who can convince you one thing when medically it is another. There was a case, for example, of an elderly gentleman who sounded to me very rational, sounded to me like he really knew what he wanted,

and then his doctor rang me the next day to say, "I have assessed him that he is legally incompetent." I have to tell you that he presented very well to me and I thought that he was switched on and I thought that he knew what he wanted, yet the doctor says, "No. He's incompetent." People can convince people without giving the real reason. That lady 40 years ago who became difficult and uncooperative, she did not have to say, "I want to die. My family doesn't want me", but her actions said that. People can convince you. I do not believe that there are any adequate safeguards.

Hon NICK GOIRAN: You mentioned earlier that you have been a solicitor for 19 years. What areas of law did you practise in?

Rev. SAUNDERS: I was involved in 24 years of legal employment, including my time as a clerk. I was involved in a whole range of areas. I subsequently, towards the end of that time, became an accredited specialist in personal injury law, but in the first 10 years I was involved in things like natural parent adoptions, criminal matters, matters to do with aged care and geriatric care and going to hearings of whether or not a person was competent—a whole range of things, even a small amount of conveyancing. I do not know why anybody would want to be a conveyancer!

Hon NICK GOIRAN: I suppose there is a need for everything! You have mentioned an accredited specialist in personal injury law. Did that include any medical negligence law?

Rev. SAUNDERS: Yes, and serious head injuries and a whole range of cases from minor to very extreme injuries.

Hon NICK GOIRAN: In your practise in medical negligence law and personal injury law, would there be from time to time circumstances where doctors would provide an opinion that would differ from another doctor?

Rev. SAUNDERS: Of course; in every case. In every case that went to court you would have competing medical evidence; you would have one doctor saying this and another doctor that. Sometimes it was a difference of interpretation; other times it was even a difference of causation, a difference of diagnosis. So, yes, those differences went from what I might call the "nuanced" differences right through to diametrically opposed diagnoses.

Hon NICK GOIRAN: Would it be common for you in your experience as an accredited personal injury lawyer specialist to have to seek out those medical opinions from time to time?

Rev. SAUNDERS: Yes, in every case.

Hon NICK GOIRAN: If one of the safeguards was to have more than one medical practitioner to provide a diagnosis, how difficult would it be to get two doctors to agree?

Rev. SAUNDERS: Can I say with the greatest of respect to medicolegal practitioners, it would not be very difficult at all. Does it come as a surprise to members of this committee to hear that in every case where you act for a plaintiff you present two or three medical reports that are very favourable to the plaintiff while at the same time in the very same case the defendant will present two or three medical reports that will say something entirely different? That is the reality of medicolegal practise in Australia.

Hon NICK GOIRAN: So you just keep shopping until you get the opinion you want?

Rev. SAUNDERS: I would like to think that we did not, but is that, in terms of the areas of interest of this committee, a realistic danger? In my view, yes.

The CHAIR: Is there anything else you want to add, reverend?

Rev. SAUNDERS: Only as a final statement to say that in my view the objective deleterious effects of laws allowing assisting suicide and euthanasia significantly outweigh any perceived subjective benefits. Even though I have only touched upon it in my oral evidence and it is not included in our written submission, I have serious concerns about the possibility, which in some jurisdictions is a reality, of medical doctors in my view falsifying death certificates to say that a person died of the underlying cause rather than the person died by his own hand or by the doctor's hand. That for me is a very serious ethical issue.

The CHAIR: Thank you, Reverend Saunders, for your evidence to the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. The committee will write to you with questions taken on notice during the hearing. Thank you very much for taking the time to speak to us today.

Rev. SAUNDERS: Thank you, Chair; thank you, members.

Hearing concluded at 11.48 am

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