

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, 13 APRIL 2018**

SESSION TWO

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**

Hearing commenced at 10.32 am**Mr MARSHALL BRUCE PERRON****Private citizen, examined:**

The CHAIR: Thank you very much for joining us this morning, Mr Perron. I am going to read the opening statement and start the hearing. 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. My name is Amber-Jade Sanderson. I am the Chair of the joint select committee. We have with us Hon Dr Sally Talbot, Mr John McGrath, Dr Jeannine Purdy, our principal research officer, Hon Colin Holt, Hon Nick Goiran and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in WA and to highlight any gaps that may exist. You have agreed to provide evidence to the committee. Your evidence is protected by parliamentary privilege in Western Australia and protected by uniform defamation laws in Australia against actions and defamation. Please note these protections do not apply to anything that you may say outside of today's proceedings. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audio-visual recording will be available on the committee's website following the hearing. Before we begin, do you have any questions about your attendance today?

Mr PERRON: No.

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

Mr PERRON: Yes, I do.

The CHAIR: Please do.

Mr PERRON: The facts are, we all know how to kill ourselves; it is done every day. If one decides that death is preferable to the life that you have, the difficult decision to face is how you are going to do it. Most of the methods chosen, as you would well know, are violent, some painful, and very messy and, of course, you cannot involve anybody else. The issue before the committee, as I see it and as I saw it back in the Northern Territory 20 years ago, is that it is all about access to the keys to the medicine cabinet. In that cabinet the government keeps the means to die a peaceful, tranquil death, but the law says you are not allowed to have any. It does not matter how horrific your life might be as a result of degenerative disease or how close to death you might be. Today the police will raid a house if they suspect you have in your possession the drug that is in the medicine cabinet.

It is often said that designing an assisted dying law is a very complicated process. I have never seen it that way. Once you decide there is a need the second thing you have to do is define the group that you believe you want to help; is it the terminally ill? Does it include the incurably ill, or even a broader group? Thirdly, you have to decide what kind of assistance that group can have. For example, is it only self-administration systems or doctor-administered as well? Fourthly, then prepare a gauntlet to be endured, that will ensure that only those who qualify get access. Finally, add monitoring systems to keep an eye on it all.

In the 21 years since the Northern Territory's Rights of the Terminally Ill Act was overturned, three major things have changed in regards to this subject. Firstly, medical advances. We can keep the dying alive even longer than they could have been. Secondly, even more adults in Australia support

assisted dying and with the leading-in to the baby boomers turning 70, I suspect that figure will grow even further. Thirdly, in the last 21 years 10 jurisdictions around the world, with a population of over 110 million, have legalised assisted dying in one form or another. I point out that they are all parliamentary democracies; they are not despot dictatorships. If the situation in those countries were as dire as is claimed by some opponents, the laws would be amended or repealed.

That is the end of my prepared statement and I am very happy to answer questions on any aspect of this subject.

The CHAIR: Thank you. It has been a long time since the introduction of the Rights of the Terminally Ill Act. We just had evidence from Dr Nitschke, who gave us his view of the act. Would you tell us what you would do differently if you had the opportunity to legislate again?

Mr PERRON: Yes, I certainly can and fairly simply. I would simply remove the compulsory requirement for psychiatric examination and make it an option if either of the doctors considered it necessary. I would include a residential requirement, which was not in the Northern Territory legislation and is probably one of the reasons that led to its downfall—the fact that it did not have a residential requirement. Lastly, I would remove the provision in the Territory act that a person who had received assistance could not be cremated. That concerned, from memory, simply in the event that there were some questions raised about the death at a later time so the body would be able to be exhumed, I guess. Anyway, I believe it would be quite unnecessary. They are the changes I would make. I do point out briefly, just while on that subject—this was the subject of discussion with Dr Nitschke, some of which I saw a few minutes ago—that the Northern Territory legislation very deliberately did not have a term to terminal illness requirement. What I and my colleagues who passed the legislation intended was that once a person was diagnosed with a terminal illness, irrespective of how long they had to live or it was expected that they might live, if they were of a mind to go through the process of determining their own eligibility, once they determined that, they could then have the peace and comfort of knowing that if the suffering ever got bad enough, they had the option to return to the doctor and seek the final stages. That means that a person may well receive eligibility status months or years before they would ever need it, but they could get on with their lives knowing that the backstop was there that they sought so desperately. That is part of why I see not having any term, and terms are problematic, as you will have heard—six months, 12 months, or whatever. There is no need for a term. I stand by the definition of “terminal illness” in the Northern Territory legislation. I think it is a good one. I have monitored every piece of legislation—the 30 pieces that have been introduced in Australia over the past 20 years.

The CHAIR: I have a couple of questions out of that. Just stepping back to removing the compulsory requirement for a psychiatric assessment: why?

Mr PERRON: I believe strongly that determining whether a person is competent enough to understand what they are asking for in seeking assistance to die is something that could easily be assessed strictly by a doctor, let alone two doctors. If those doctors had any doubt in their minds that the legislation should obviously require referral for a psychiatric opinion, what they are determining is not whether someone is—I am probably using the wrong word—sane; we are really talking about whether they understand the ramifications of what they are asking; are they rational in that respect? We are not asking them whether they are rational in other respects so I believe it is a test that the average doctor could pass, easily.

The CHAIR: Can I just ask you about this eligibility issue. We have heard a lot of evidence that those who are granted eligibility or access to voluntary assisted dying or medically assisted dying do not use it. Why is eligibility to people so important?

Mr PERRON: Eligibility? It is because people seek it, as I understand it, and as I would myself, as an insurance policy simply that if the disease that you have progresses to a point where life is simply unbearable and you decide that death is preferable to the life that you are living. So I understand completely the figures, particularly from Oregon that are quoted regularly, that I think it is one-third of people who receive eligibility status do not actually take the medication in the end. I think that is a big plus for legislation, not a minus. The other aspect that this raises, which is not often raised in euthanasia debate, is the extraordinary benefit to society of the comfort of mind that it will give people, even before they are ever ill or old or terminally diagnosed, the comfort that that will bring them that if things are bad enough they have an option; they can make an approach and determine eligibility and perhaps get assistance. At the present time, if you do not have that option, which we do not, and you face diseases—an extreme example, of course, is motor neurone—and you are just saying to yourself, “My future is predictable. The time line may not be, but the future of how I am going to die is predictable, and my only decision is when am I going to pull the plug, or am I going to stay there until it happens naturally”, and I think a lot of people would draw huge comfort from simply knowing that legislation was on the books in this situation.

Mr J.E. McGRATH: So would you say that this eligibility status that you talk about would be more suitable for people with things like motor neurone where it is very debilitating and it gets worse progressively, rather than someone who is closer to the end of life?

Mr PERRON: The first group you mentioned—the motor degenerative diseases—is really in my mind top of the list of people who, if you had a tiny group who were eligible for assisted dying and no-one else it could be that sort of group with those very slowly debilitating diseases that leave you totally and absolutely dependent for every single bodily function. And for that group of course you need a very long period, as was discussed in Victoria, which you would be aware of, why they went for 12 months for that group and six months for everybody else. Closeness to death for me, I think, is somewhat irrelevant. You have got to understand that the reason why people want to put six months, or even less, on the estimated life left is that there seems to be some thought there that people are going to rush forward to be assisted to die. It is just simply not the case. People do not want to die. Even those who apply do not want to die. So we have been in a situation in Australia all these years with many pieces of legislation being proposed and failing, all trying to outdo each other almost with safeguards—Victoria is the example of that, of going as far just about as you can—all on the basis that we have to somehow stop this horde of people getting over the gates to kill themselves. I think we need to take a few steps back and look at this thing rationally. People do not want to die. There will not be a huge rush for this sort of legislation, so why we are trying to put up these barriers—this gauntlet that people have to run—which is almost to the point in Victoria, hopefully not, where people say, “Well, I’ll go back and use the rope or the tall building or the electricity”, or whatever, which they are using today.

Hon COLIN HOLT: People want to stay alive as long as they can. What about safeguards to guard against coercion or family pressure, where the family can put a lot of pressure on someone—or anyone could really—to say you need to take that final step. Safeguards for that? Any thoughts?

Mr PERRON: Yes, my thoughts on that are that again we need to consider that family life is not such that the kids are trying to get rid of the grandparents to inherit the estate, although I am not saying it does not happen. But we should not sort of look at this legislation with a view that, other than a normal reasonable assessment by two doctors, people are acting genuinely and without coercion and of free will. But to go beyond that and try and draft legislation that gets into the minds of people much deeper than that, it gets to almost an absurd stage. What stops people today from encouraging their other relatives to turn off life support machines of the elderly earlier than is necessary, to sign do-not-resuscitate orders for the elderly who perhaps are slowly losing their

minds and are in hospitals or aged-persons homes? I think coercion can already be there—maybe it is—but we shouldn't isolate this issue and make it such an issue that we do not proceed with legislation.

Hon ROBIN CHAPPLE: Thank you, Marshall. I am going to call you that because we do know each other.

Mr PERRON: We do.

Hon ROBIN CHAPPLE: When it comes to witnesses, doctors and people involved in the process, one of the things that I tried to introduce into my legislation was that none those people involved in signing or witnessing documents or being involved in the process could have any interest in the process—that is, a family member who was a beneficiary, a doctor who was bequeathed something in the will. Do you think there is a need for something in the legislation to deal with that?

[10.50 am]

Mr PERRON: I do, but it would need to be a very simple few words. I think the Northern Territory legislation hits the mark. It is that witnesses were not to be relatives or otherwise beneficiaries. I do not think we should make too big an issue of the witnesses in that respect. They are merely witnessing the signing of the document, and to the extent that they know it is being done of free will. It is still at the bottom order of, say, for instance, in my view, witnesses. You do have them. But if I can just turn to your legislation, if you would not mind, Robin. I refreshed my memory over the last couple of days because of your 2010 bill. I think if you went too far in that respect, it was that you had to die within two years, or be predicted to die within two years, although that is better than Victoria. Aged 21; everyone else goes for 18. Only a doctor can administer. That was unique to your legislation. It is interesting to see the difference in attitude. Your bill only allowed administration basically by injection, I guess, by a doctor. That presumably was to avoid self-administration, where someone might regurgitate an oral drug—I guess that is what it was for—and cause all sorts of problems there. Victoria, at the other end of spectrum, one of their earlier bills specifically had a clause in it prohibiting assistance by injection. That was to remove the stigma that people would feel that anyone in a white coat in an aged-persons home with a syringe in their hands was potentially going to murder them—the ridiculous stuff that is peddled by some of our opponents at times. There are two extremes from opposite ends of Australia of how you handle the safeguards. So that was in respect to the nature of the assistance being given. Can I just say on that—I think this is important—that I believe that self-administration obviously is the ultimate, and there are potentially problems, I think, with oral administration only, a la Oregon. For example, what if you cannot swallow or have difficulty swallowing? I think that the idea of self-administration, but the legislation allowing a doctor to prepare medication for self-administration is something that was talked about in the Northern Territory, and Philip Nitschke, of his own volition, decided that an intravenous line, with a syringe hooked up, activated by the patient, was an ideal way to go. We would have the benefit of direct injection as far as efficiency was concerned of bringing on death quickly, and it avoided all the issues of oral.

It also meant that the doctor did not actually, as Philip Nitschke said, execute the patient. I think some legislation in the past in Australia has not provided that. It has either had oral only or oral and a doctor could assist if the patient could not self-administer a la Victoria. My idea is that with modern technology, if the doctor is permitted to put an intravenous line in and a syringe driver, a patient can self-activate if they can blink an eyelid. In that case, I would think it almost removes the ultimate requirement: can a doctor administer? I believe that modern technology, with the right legislation, would allow only self-administration but it must allow for a doctor to prepare the necessary drugs and for the administration by the patient. Sorry to go on this long.

Hon ROBIN CHAPPLE: If I may, I have a couple of small points on that. There are two questions. Should a doctor be there in case for some reason? I am answering my own question here: if it is self-administered, that is fine. What happens in the case of motor neurone disease where we are obviously dealing with another level of a terminal illness but quite often people have reached the stage where they cannot do anything. What happens there?

Mr PERRON: I am not an expert of course, and you heard some chilling evidence from the Motor Neurone Disease Association in Western Australia, which I read. I believe that even in very advanced stages, the very final stages of motor neurone disease, people would be able to, for example, move an eyelid. This is not said in jest. As you probably know, Stephen Hawking was an example who has lived many years as one of the great brains of humanity activating everything he wanted to do by a muscle in his cheek. To answer your question, I think that modern technology, with some careful thought by the relevant experts, could enable almost anyone to self-administer.

The CHAIR: In your submission, Mr Perron, you talked about the Victorian and the recent New South Wales bill, and you outlined that you thought that the New South Wales bill was a better bill. Can you give us a sense of why that is?

Mr PERRON: Yes, I can. Firstly, can I just start by saying with the New South Wales bill, there are four things that I would recommend changed; otherwise I thought it was pretty reasonable legislation. Firstly was the 12 months to die. As I have already stated, if we are talking about a terminal illness, I do not think there is a need for a term at all. Secondly, the New South Wales bill unusually had the minimum age to be 25 years. No-one could explain to me why that figure was chosen. I think it should be 18. It also says that there is a compulsory psychiatrist examination in New South Wales, as the Northern Territory legislation did, and I disagree with that. Lastly—this is my biggest objection to the New South Wales one—a relative may apply for a court order to challenge an application. Providing anyone the right to challenge an application is burning the principle of autonomy. Surely if there were any time in life when your opinion should prevail, it would be on your deathbed. We well know stories of the long lost son and so on who come out of the woodwork five years after someone has been ill and suddenly start complaining about things. I object strongly about that. They are the few changes I would make to New South Wales. In the Victorian legislation, if I can comment on that, Chair.

The CHAIR: Yes, please do.

Mr PERRON: My objection to the Victorian legislation, although I have to say, being an activist for the last 21 years, I am really pleased obviously that Victoria finally got legislation through the system. However, to do so they have made it, as the Premier has declared, probably the most conservative legislation in the world. I am not sure that that is a thing we should be so proud of, but at least we have legislation. I understand in politics it is the art of the possible. It was possible in that case. However, I think there are couple of the major faults with the Victorian legislation. After the whole process of two doctors, et cetera, et cetera, and witnesses and forms and whatever, a doctor at the end of the process finally applies to a public servant, the secretary of the Department of Health, for a permit for self-administration, or a permit for the doctor to administer if the patient is not able to. I think that is a step which is totally unnecessary, completely out of the blue, and I guess the public servant in that case just does all the paperwork. He does not necessarily have any medical qualifications. They review that all the paperwork has been ticked off correctly. I think it is a complete time-consuming step. It will take, if not hours, maybe days, to get such a permit. We are talking about people who are suffering so badly that they want to die. Let us not delay it any longer than we have to. The Victorian legislation also allows the Victorian Civil and Administrative Tribunal

to review an application while it is in process and issue orders. It can review residency status, competency and other procedures that are partly through the process of an application.

[11.00 am]

So then we have two steps there in my view that are just totally unnecessary. The VCAT review is analogous, I guess, to the court order in New South Wales where you can intervene in a process and say, "Something's wrong here. I want it stopped." Well, for goodness sake, let us have some thought for the patient. The last one in Victoria was, I thought there was almost paranoia about what drug was going to be used and the fact that the government could not say with certainty it would be Nembutal, the gold standard for taking one's life, as Philip has pointed out, because it is currently banned for human use in Australia. I point out, however, that despite this paranoia about the drug or whatever lethal drugs the chemist or the pharmacy is going to put together—and it had to be in a locked box and that raises the question as to who has got the keys, where is the locked box stored in someone's home, who else has access? It was all paranoia as if there is nothing in your household that is poisonous or dangerous now or that you cannot go and buy in Bunnings and look under your sink. I mean, there are batteries in kids' toys today that will kill them within hours—and has done so in Queensland. Here we are talking about adults handling a prescription for a lethal drug. There are probably thousands of doses of Nembutal in Australia in every vet's office across the country; maybe hundreds of vets, I am not sure how many vets there are. In fact, I think it is over 1 000, and probably a couple of thousand of their staff have access to Nembutal with very little, if any, controls—certainly no legislative controls that I am aware of. Vets do not even keep records, I believe, accurate records for the expert authorities to look at of how much Nembutal is consumed by a veterinary office. I believe that they have actually objected to suggestions that these controls are kept. I mean, how much Nembutal would you need to kill a whale or an elephant or whatever? We see that they euthanase now these creatures, whales on beaches and dolphins and things that get stranded, racehorses as we know and other animals they euthanase where it is required. The country really is awash with Nembutal. Let us not get paranoid about the fact that legislation is going to be so involved over this very issue. If I can just briefly lay my hands on it, the Northern Territory provision in regard to the drugs—I cannot lay my hand on it instantly. It basically says that the doctor will use appropriate drugs having regard to the circumstances and condition of the patient, particularly raising avoiding getting involved in the doctor-patient relationship as far as the clinical activity was concerned. The huge variety of conditions that people are in at the end of life means that there could be a number of different drugs that would actually end their life, maybe not even Nembutal but other drugs. But the Northern Territory guidelines, which were issued with the legislation to doctors, certainly gave the doctor the leeway to make these decisions. I do not think legislators have any role here as to what drugs were used and in what quantities. However, the guidelines—I have probably a pretty rare copy I could send to the committee if you like, which was prepared for Northern Territory doctors by the Chief Medical Officer of the Northern Territory—includes the list of drugs and doses which were suggested or recommended that the doctors consider in ending life, because effectively there was not a lot of information available in the public arena back in 1995, but the Northern Territory health department set about finding out as much as they could on the subject to pass on to doctors.

Hon NICK GOIRAN: Mr Perron, I was interested in your response to the chairman's request for you to outline the changes that you would advocate for on the New South Wales legislation, and you listed four things. It is the fourth of those things that I want to take you to. I think I understood you said that you had an issue with a relative being able to apply to challenge an application.

Mr PERRON: Yes.

Hon NICK GOIRAN: Why would a relative want to challenge an application?

Mr PERRON: That is a question I would find difficult to give you an answer, and I do not think that takes away from the credibility of my opinion. I really cannot think of why someone would want to challenge it other than they just simply presumed that they were doing the wrong thing or they wanted them to hang around a little longer. Perhaps the latter.+

Hon NICK GOIRAN: Could it be that perhaps relatives do not always agree?

Mr PERRON: Absolutely. It would take one to disagree to initiate an application to a court.

Hon NICK GOIRAN: Indeed. So if one relative was concerned that the applicant had been pressured or was under duress, should they not have the right to challenge that or should we wait until it is too late?

Mr PERRON: I do not believe there should be a right to challenge it. I am a strong believer in personal autonomy. If you assess a person as being competent to make this decision—they are a competent adult—that, in my mind, makes their opinion paramount to everyone else, including spouses, children and parents—paramount. We are talking about people who are in most cases close to death, certainly people who are suffering such—we know that it is subjective judgement and that is why it should be the patients alone—suffering to a point where they prefer to be dead than alive, and I think that anything that brings an external authority into delay the process is undesirable.

Hon NICK GOIRAN: So long as they are competent, that is okay?

Mr PERRON: Yes. Competency means you know what you are doing—the ramifications of what you are doing.

Hon NICK GOIRAN: Does it matter if they were under duress?

Mr PERRON: I believe that the duress question, which is in virtually all legislation, including the Northern Territory legislation, is one of the criteria that is assessed by two doctors in almost all cases of safeguards, and I believe that considering these are not short meetings between doctor and patient, I think that the demeanour of the patient could be assessed by doctors reasonably, particularly two of them, including the question of whether they are acting under coercion.

Hon NICK GOIRAN: So the safeguards are the doctors?

Mr PERRON: In this case, yes.

Hon NICK GOIRAN: Should those doctors have had some rapport with the patient?

Mr PERRON: Not necessarily.

Hon NICK GOIRAN: Might a relative have a better understanding on whether somebody was under duress than a practitioner who meets the person for the first time in a brief consultation?

Mr PERRON: My answer simply is the patient's view in these circumstances, being competent, being assessed as competent and being determined as they are to commit to this process, their view should prevail. Whether there was one or more relatives who were protesting most loudly, I believe should be of no consequence in delaying the process.

Hon NICK GOIRAN: Have you got a copy of your submission handy?

Mr PERRON: Yes.

Hon NICK GOIRAN: At pages 5 and 6 of your submission, you say that there is, however, a number of requirements common to them all, and you are talking there about the legislative models. You go on to say, these are that the applicant must act voluntarily, without coercion, be informed and multiple medical opinions to confirm diagnosis. Do you still maintain that today?

Mr PERRON: Yes.

Hon NICK GOIRAN: What redress options did your Northern Territory law include in the event that these requirements were breached?

Mr PERRON: I cannot recall the penalty provisions in the legislation immediately. Whilst I browsed through the act a couple of days ago, it has been a long time.

Hon NICK GOIRAN: Yes, sure. I was not too concerned about penalty provisions; I was more interested in redress options.

Mr PERRON: Can you explain a bit further?

Hon NICK GOIRAN: There is a distinction between a penalty and redress. A penalty is a provision that is imposed upon somebody who has breached a provision of the law. Redress is available to those who have suffered as a result of a breach in the law.

Mr PERRON: I guess you are referring to the relatives of the applicant being the ones who suffered because the patient supposedly was assisted to die as a result of duress or partly as a result of pressure.

[11.10.am]

Hon NICK GOIRAN: Yes, but I am asking you with respect to your legislation—I do not profess to have the expertise that you have of your own legislation—but you have indicated that there are a number of requirements that need to be common to them all, and of those requirements I am asking: if they are breached, what redress options did you outline for people?

Mr PERRON: I would have to come back to you on that. I just do not have that recollection of the act in detail before me.

Hon NICK GOIRAN: Would you mind taking that on notice for the committee?

Mr PERRON: Absolutely.

Hon NICK GOIRAN: That would be wonderful.

Hon Dr SALLY TALBOT: Mr Perron, I am interested in the attitude of the medical profession. When you introduced the law in the Northern Territory, we understand that local doctors did not exactly rush to get on board and we have heard evidence from the AMA which clearly delineates their position. Can you talk a bit about the attitude of the medical profession?

Mr PERRON: Yes. The medical profession in my view acted disgracefully during the campaign for the legislation in the Northern Territory. They have a right, of course, to oppose as the AMA has generally done of all legislation to date. When the legislation was finally passed—the information I have on this largely comes from Dr Nitschke, who has made many public statements over the last 20 years, including to committees such as this one, and you have heard from him statements that no patient would ever be assisted and they would stop the legislation ever being implemented et cetera—the AMA was party to a lawful challenge, a court challenge of the legislation's validity, which they were entitled to do, I appreciate. They were also party to an appeal to the Prime Minister to use a section of the government act which allowed the Governor-General to overturn legislation of the Territory, and that appeal by the AMA to Prime Minister Keating fell on deaf years. I am pleased to say the Prime Minister rejected it saying this was a matter for the Northern Territory. As we know, subsequently, a private member's bill in federal Parliament was successful.

Getting back to the medical profession, there were doctors supportive of the legislation—a few—because the association of general practitioners accepted the role offered to them by the Territory health department of preparing an education program for doctors. I mentioned a brief, which I will

forward a copy of to the committee that was a result of the preparation by the association of medical practitioners. Those doctors, however—that action occurred, of course, prior to the legislation coming into force, the preparation of the educational material and a bit about drugs et cetera—stayed well hidden in the period after the legislation was passed when Dr Nitschke was desperately trying to get another doctor to even see and confirm or deny diagnosis of a patient who was an applicant. Phil was a very high-profile, very newsworthy person, as he still is, and most doctors are fairly conservative. I believe those who were supportive—there was probably only a few—kept very much underground during the period public furore, including the patient Janet Mills' television appeal, which was successful, for a doctor to come forward to examine her that resulted in the case that was mentioned of the specialist who was not a specialist in the relevant disease signing off on it because he felt so bad about this woman's plight. I will stop there but simply to say that it was the first time in the world that it had ever happened. The AMA and the churches were absolutely determined to stop it in its tracks because if it passed in the Northern Territory, where would the floodgates ever stop? I am sure we were very high on the priority list of doing whatever was required to prevent the legislation, firstly, passing and, secondly, being in any way implemented successfully. To a small degree, they were successful.

Hon NICK GOIRAN: Mr Perron, would you describe the signing off by the orthopaedic surgeon as a success?

Mr PERRON: Obviously, I guess I can only stand by the words that Philip has said. He has acknowledged, I believe, publicly if not in this forum—I did not hear all his evidence because the video connection was playing up here—but he has been asked the same question in other parliamentary committees, and I gather the answer is that it was not necessarily in accordance with the legislation's intent, but no party involved regrets what they did in that circumstance.

Can I finally say, of the four people who used the legislation, in my view, and I am not a doctor, I say that I believe and I know two families of the four people who used the legislation who are hugely thankful for the opportunity that their loved one had. The four people who were involved, I believe, were competent, they were adults and they were terminally ill to the extent that I know about these things having tracked it all pretty closely.

Hon ROBIN CHAPPLE: Thank you, Marshall. You mentioned earlier on in your presentation that the one thing you would change in the Northern Territory legislation was that you would make it residential. Can you give us some reasoning around that?

Mr PERRON: Yes. It did come up when we were preparing the drafting instructions: should we limit it to Territory residents? My attitude and the attitude of the Leader of the Opposition at the time, although we were talking to each other as Independents, of course—the bill was a true example of parliamentary democracy in its passage—we believe that if the motivation for such legislation is compassion for the dying, would it be right if we had two people in an institution in Darwin or a hospital who were dying alongside each other in a bed, one was a Territory resident and therefore entitled to assistance to die, but the next one, if they had an identical problem medically, was not entitled to assistance. To us that seemed simply wrong so we did not put in a residential requirement. In doing so, however, it probably sounded the death knell for the legislation. I know that Kevin Andrews and his cohorts were incensed that the Northern Territory had, in fact, legalised voluntary euthanasia for the whole of Australia. They could have gone further and said that they had legalised it for the whole of the world, because it may have been a Japanese tourist who was hit by a bus and found themselves—probably being hit by a bus does not give you a terminal illness, does it, but I think you know what I am saying. By not putting in a residential requirement, two of the four people who used it came from interstate. They both came from states where there is fairly

reasonable and good palliative care, New South Wales and South Australia, and two from the Northern Territory. Had it been limited to the Territory residents, it may have taken the edge off the national debate that was successful in federal Parliament, because we only lost the Senate by two votes in defeating Kevin Andrews' legislation. Anyway, that was not to be, and I think the residential requirement in hindsight was a political mistake on my and our behalf.

The CHAIR: Mr Perron, was there anything else you would like to add?

Mr PERRON: Can I just touch on a last item, but not to hold up the committee anymore?

The CHAIR: Yes, please do.

Mr PERRON: I just want to say—I am reading from my list here very quickly—two things. One, the principle that I always quote regarding this law, and that is that the law that is proposed does not require anybody to do anything. Anybody who disagrees with the principle of assisted dying should conduct their lives as if the option did not exist. Lastly, can I just advise the committee that I have had experience over 20 years and if legislation is to succeed in Western Australia, if this process goes that far, it must be a government bill, as was the case in Victoria. All the 30 bills introduced into Australia so far have been private members' bills. I have tracked them all. It requires cross-party support before a bill is introduced so that there is support to carry it through. The decision of the Victorian committee to recommend that it be a government bill was primarily because the government has carriage of it in the procedures of Parliament, and that makes a big difference even though the government members, of course, were all given a conscience vote on the issue. I point out that in your recommendations, if it gets that far, I urge you not to recommend that a private member take the matter up and introduce it, because I do not believe a bill would succeed on that basis in my reasonable experience. Thank you for the opportunity to address you today.

The CHAIR: Thank you very much, Mr Perron, for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. 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 what you said 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 any questions taken on notice during the hearing. Again, thank you very much for your evidence today and for the submission you have provided to the committee. It is very helpful.

Hearing concluded at 11.22 am
