

JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

*First Report — “My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices” —
Tabling*

MS A. SANDERSON (Morley — Parliamentary Secretary) [10.09 am]: I present for tabling the report of the Joint Select Committee on End of Life Choices titled “My Life, My Choice”. I also table the submissions provided to the committee.

[See papers 1590 and 1591.]

Ms A. SANDERSON: Overwhelmingly, people want to live. For those left behind, the protracted death of a loved one from a terminal or chronic illness can be devastating. These were just two of the clear messages from the hundreds of people who shared their accounts of grief and loss with us. Although the report outlines many of these accounts, it has not been possible to include them all. One account, about a woman named Melanie, was particularly haunting. Some of Melanie’s story is contained in the report. She suffered with advanced motor neurone disease and could not find relief from her terrible symptoms. Faced with limited options, in the end she chose to starve herself to death.

The committee received hundreds of submissions from people who watched on powerlessly while a family member or friend experienced a protracted and painful death. In the report, we aim to tell these real stories of human suffering rather than simply relay the clinical details. On behalf of the committee, I want to sincerely thank everyone who took the time to make a submission and those who gave evidence at the hearings, often recalling the painful and distressing experiences of their loved ones. Some were very recently bereaved.

How we die has changed over the last 60 years. Medicine and law have not kept pace with this change, nor with the changes in community expectations. Many of us are familiar with the deaths of our grandparents and other elderly relatives who passed away peacefully in their sleep, often at home. This is not now the common experience. Modern medicine has given us greater longevity, but it has also delivered longer periods of dying. People now survive a lot longer than they did, but often with debilitating symptoms. The truth is that many of us may face a protracted death at an advanced age.

Over the course of this inquiry, the committee found that too many Western Australians are experiencing profound suffering as they die. This is in part due to inequitable access to palliative care. However, it is clear from the evidence that, even with access to the best quality palliative care, not all suffering can be alleviated. Palliative care physicians themselves acknowledge this. Many life-limiting conditions that cause profound suffering cannot be completely palliated. The committee heard from individuals and health professionals about the terrible effects of some of these illnesses, such as motor neurone disease, Huntington’s disease, dementia, Parkinson’s disease and some cancers. The report explores what it is like to die from these illnesses, and it makes difficult reading.

According to national coronial data, around 10 per cent of suicides in Western Australia are by people with a terminal or debilitating illness. This is similar to estimates in other jurisdictions, including the United Kingdom and the United States. These people die lonely and often violent deaths, including through plastic bag and helium asphyxia, carbon monoxide poisoning and self-inflicted gunshot wounds and by hanging. Some individuals who suicide under these circumstances are driven to take their lives early. It is almost impossible to quantify the number of people who attempt suicide and fail and are often left further debilitated, although there is evidence that this occurs. These suicides are devastating for family and friends and can traumatise first responders. Evidence from the Commissioner of Police supports this view.

The committee concludes that the current lawful options available to people experiencing grievous and irremediable suffering at the end of life are inadequate and can be exceptionally difficult for the dying person and their family and friends. One of these options is refusal of food and water—also known as palliative starvation. A competent individual’s absolute right to refuse food and water and to refuse medical treatment is clear in law. At the end of life, those refusals are not suicide. Health professionals providing palliation for those who choose this difficult path are not aiding suicide; they are providing good palliative care. There is, however, uncertainty among some health professionals about both these absolute rights for individuals and the protections afforded to health professionals under the law. There was also a disconnect in the evidence we received from health professionals, who assert that this practice is very rare, and the many submissions we received from individuals outlining circumstances in which their friend or family member had elected to end their life in this way. This practice could be more common than publicly acknowledged.

The report also notes that there has been a cultural shift across the community away from “doctor knows best” to individuals wanting more say over their medical treatments. The principle of patient autonomy emerged during the 1970s and is now a critical feature of modern medical ethics. This principle means that competent patients are free to make their own medical treatment decisions. The earliest expression of medical ethics in the western world is contained in the ancient Hippocratic oath from around 470 BCE. Many aspects of it survive today; however, other

aspects have no application in modern medicine. The contemporary Declaration of Geneva builds on some of the principles of the Hippocratic oath and has been adopted by the Australian Medical Association. The current Geneva declaration provides for a physician's pledge that says, "I will respect the autonomy and dignity of my patient."

The committee recommends that the government legislate for a voluntary assisted dying scheme in Western Australia. The recommendation responds to the unnecessary suffering experienced by too many people at the end of their lives and to acknowledge community expectations regarding individual autonomy. The committee recommends that the bill be drafted with the guidance of a panel of experts, including health and legal professionals and health consumers. The panel will provide a means for the government to undertake careful consultation with key stakeholders in the development of the bill. The report sets out a recommended framework for a voluntary assisted dying bill. The framework recommends safeguards and rigorous processes that are critically important to the safe functioning of any scheme. Establishing eligibility by ensuring individual decision-making capacity and the absence of coercion, together with non-discrimination, are critical elements of the framework. Participants should be 18 years and over and ordinarily resident in Western Australia.

In the course of the inquiry, the committee found that including a predicted time frame until death as an eligibility criteria can result in some individuals being unfairly excluded. Also, time lines may not be clinically justified. People with a progressive chronic and neurodegenerative disease may experience intractable suffering for months or years before they die. The committee has chosen not to ignore the suffering of these individuals and acknowledges that physical pain is not the only form of profound suffering at end of life. The committee has recommended that those who are eligible for voluntary assisted dying must be experiencing grievous and irremediable suffering related to an advanced and progressive terminal, chronic or neurodegenerative condition that cannot be alleviated in a manner acceptable to that person, where death is a reasonably foreseeable outcome of the condition.

A person's decision to end their own life in the face of terminal illness that is causing profound suffering is a rational choice for some. It is not necessarily a medical decision, but in some circumstances it may require the assistance of a medical professional. Assisting someone facing hopeless circumstances to die peacefully with friends and family in a setting of their own choosing is a humane and compassionate act. It is fully in keeping with modern medical ethics and community expectations. The committee acknowledges that some health professionals will not want to be involved in the process and accordingly recommends that there should be no compulsion for individuals to participate.

The committee also reviewed international jurisdictions that have legislated for some form of voluntary assisted dying. There are volumes of peer reviewed research and data on the various models, some of which have been operating for more than 20 years.

We heard from those opposed to voluntary assisted dying about the dangers of a slippery slope. Proponents of this argument contend that once a scheme is introduced, it will inevitably expand to include vulnerable groups such as children and those with mental illness. They assert that a particular course of action will inevitably lead to another action with unintended consequences; in other words, it implies something out of control or unmanageable. The committee finds no evidence to suggest that this has occurred in the jurisdictions that have legislated for voluntary assisted dying. Each jurisdiction has its own unique legal framework resulting from considered legislative processes and court rulings in those countries. The Oregon legislation, for example, has never been amended in the 20 years of its operation. I caution against drawing the wrong conclusions and lessons from international experience.

The committee rejected these overseas models. The model our Parliament is asked to consider should be in line with the expectations of our community and reflect the values and safeguards we deem appropriate. Palliative care was the single largest issue examined during the inquiry, and it became clear that much work is needed to ensure that palliative care services are able to keep pace with growing demand. We met many dedicated professionals involved in palliative care and were consistently impressed with their commitment and dedication to those they care for. Western Australia has the lowest number of publicly funded inpatient beds per capita, and access to specialist palliative care is limited across the state. Access is even further limited in rural areas, and almost non-existent in remote regions. In an extraordinary admission, the WA Country Health Service told us "there is limited oversight, coordination and governance of medical palliative care services across WA Country Health Services". This must be urgently addressed by the state government.

Both Palliative Care WA and the Department of Health acknowledge that wealthier, better educated Australians have better access to palliative care. This is a trend reflected across the healthcare sector, and needs to be addressed. The home and community palliative care model currently delivered by Silver Chain in the metropolitan area is a highly regarded and valuable service that is recognised across Australia. This model should be expanded. Multiple health conditions and comorbidities mean individuals may have more treating specialists and less overarching coordination of care and advocacy. This results in gaps in care, particularly when patients move from different palliative care settings, such as from home to hospital. The need for better coordination and integration

of palliative care services was raised by many witnesses. The committee is in no doubt as to the effectiveness of palliative care in the majority of cases; however, there are circumstances in which palliative care cannot relieve all the pain and suffering caused by late-stage symptoms. The percentage of patients for whom symptoms cannot be managed varies between two and five per cent. Some experienced medical professionals gave evidence that it could be as high as 30 per cent. The fact also remains that some people with terminal and chronic illnesses do not want to be palliated.

Advance care planning formed an important part of this inquiry. It is clear that advance health directives are poorly understood by health professionals and the wider community. The statutory form is very difficult to complete and can be equally difficult for medical professionals to interpret. They are particularly challenging in emergency settings—often when they are most needed. A concerning trend in both public and private settings is that some providers are promoting non-binding advance care plans and goals of care over the legally binding advance health directives. Although helpful planning tools, they are not legally binding directives and the committee is concerned that a patient's legal rights are being downplayed in this process. The committee heard evidence that a treating doctor may consider the directive not to be in the patient's best interests, or that the expressed wishes do not fit with the healthcare provider's policies; however, there are organisations that promote and use them well. There can be a real cost for the patient and families when active treatment is pursued regardless of an earlier express refusal of treatment. These treatments can lead to significant debilitation. The committee made a number of recommendations for the Attorney General and Minister for Health to improve the useability and uptake of and education for these important legal instruments.

Dementia is now one of the most common terminal illnesses in Australia, and the number of people affected is rapidly increasing. Around half a million people in Australia are living with dementia. This is a challenge of monumental proportions for policymakers and governments and is reflected by demands from individuals that their healthcare wishes be honoured once they have lost capacity. This was a strong theme amongst submitters. This report does not purport to have the answers to this complex area, but it does direct the government to carefully examine the question of dementia and advance planning. As chair of this joint select committee, I wish to thank those who shared their stories with us. Committee members accompanied Silver Chain nurses on home visits to palliative patients to see firsthand the work they do. We also visited palliative patients at Sir Charles Gairdner Hospital and a number of hospices. These visits were invaluable for committee members and helped us to understand this important sector and some of the challenges it faces. Thank you to those who let us into their homes and to those who spoke with us at a difficult time. I particularly acknowledge those who are no longer with us.

This inquiry was an enormous undertaking, receiving around 700 submissions and holding 81 public hearings. The community is ready for this debate. I thank the secretariat staff—Marion Huntly, Michele Chiasson, Pam Clarke, Mathew Bates and Dr Jeannine Purdy. Without them, we would not have gathered such quality evidence to draw from. The secretariat worked through some very difficult issues and mountains of evidence with focus and equanimity. Ultimately, it is the secretariat that does the heavy lifting, and as chair I feel very fortunate to have worked with such talented and dedicated people.

Similarly, I want to thank my fellow committee members. We spent many hours together, discussing and deliberating on this issue. The process was respectful, rigorous and thorough, with everyone making an important contribution. Those who fundamentally oppose the introduction of voluntary assisted dying lack rigorous evidence to back up their claims. They will inevitably criticise this process. I am proud to have led this inquiry and stand by the many hundreds of people and experts who participated. I stand by my fellow committee members from across the political divide and the conclusions we reached in this report. In the words of submitter Mr James Hindle —

The ultimate act of compassion is surely to allow someone to choose to end their suffering, even when we want them to stay with us.

I commend the report to the house.

Government members: Hear, hear!

[Interruption from the gallery.]

The SPEAKER: People in the public gallery, we love you being here, but we have a process to keep going. We accept your applause, but can we just keep it down a bit. The member for South Perth will now make his contribution.

MR J.E. McGRATH (South Perth) [10.26 am]: I rise to speak to the report of the Joint Select Committee on End of Life Choices. When I put my name forward to serve on this committee, I did so with no preconceived views on the subject and no real personal experience through the passing of loved ones. Some would say that I have been most fortunate in that regard. But I, like many others in the chamber today, have heard stories of how people have

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passed away. If nothing else, the experience of serving on this committee has informed me greatly on what is a very complicated and sensitive issue. Death is a fact none of us like to talk about. We often hear people say, “I don’t want to be kept alive if I am somehow left in a vegetative state with no quality of life.” The truth is that that decision is often taken out of the person’s hands because they have lost what the medical profession describes as decision-making capacity. Another common misconception is that in an act of compassion, doctors regularly speed up the death of patients at the end of their lives. How many times have we heard someone say after the death of a loved one, “Oh, dad was suffering, but in the end the doctors increased the morphine and that speeded things up”?

Dr Anil Tandon, chairman of WA Palliative Medicine Specialist Group, informed the committee that pain medicines and sedatives at the end of life do not hasten death. Other clinicians all agreed that it is still the underlying disease that brings about the person’s death. Moreover, any doctor bringing about a patient’s death in such a way could be liable under section 259 of the Western Australian Criminal Code, unless it is done in good faith and in the exercise of reasonable care and skill.

Exactly 12 months ago today the committee was asked by Parliament to investigate end-of-life choices under four terms of reference: first, current medical practices for those at the end of life, including palliative care; second, international and interstate experiences, and recent reforms; third, possible legislative changes; and, fourth, the role of advance health directives and enduring powers of guardianship and attorney. I am well aware that this will be the most contentious issue dealt with by this Parliament since the passing of legislation to abolish capital punishment and to decriminalise abortion.

The committee process has indeed been an exhaustive one. We took evidence from every peak health body and listened to many members of the public who had differing opinions on end-of-life choices. We travelled to hospices around the state, and individually each member had the experience of visiting the homes of some palliative care patients along with a Silver Chain nurse. That was quite a moving experience. We also visited Sir Charles Gairdner Hospital, as the chair said, where we met Dr Tandon and people receiving palliative care at that hospital.

In evidence, the Western Australian division of the Australian Medical Association reaffirmed its opposition to voluntary assisted dying, but president Dr Omar Khorshid said that the AMA would want to be involved for the state government to put in place any process to bring legislation into effect. Dr Khorshid told the inquiry —

It was very clear to us that we need to accept that the public is saying that their experiences of end-of-life are not what they should be.

...

... the view of the AMA WA is that if we go down this path, we would strongly recommend a very restricted model making voluntary assisted dying available to people with terminal illnesses only.

Much of the evidence the committee heard was personally quite confronting. The subject of voluntary assisted dying became an issue for me in March last year when a constituent, Mr Clive Deverall, faced with irreversible chronic illness, pain and suffering, chose to end his life on the morning of the state election. Mr Deverall had been CEO of the Cancer Council of WA from 1977 until 2000 and was well known as a champion of palliative care. In later life, he became a champion for voluntary assisted dying. In giving evidence to the committee, his widow, Ms Noreen Fynn, referred to a speech by Professor Brian Owler, a past president of the AMA, when she said —

... the desire to live is the strongest of human instincts and that people endure pain and suffering when there is hope of recovery or improvement. For those who seek assisted dying, it is not a choice between life and death; it is not about giving up the fight to live. It is about the relief of suffering, choice and control. It is about quality of life over quantity, about respect for a person’s choice about the manner and time of death.

The committee also heard some disturbing evidence about the suffering and quality of life of people with neurodegenerative diseases such as motor neurone disease, Parkinson’s disease and Huntington’s disease. Michael Watkins was a young man who joined the Navy but was later diagnosed with Huntington’s, which he acquired from his biological father. Michael’s stepfather, Bill Spanbroek, gave evidence to the committee about the suffering Michael had to endure. This is what Mr Spanbroek told us —

We looked after Michael ever since he was 21, when he was asked to leave the Navy. We had numerous discussions and lots of very good discussions with the Navy about why he should be in it, because the Navy never diagnosed him and he became quite active by wanting to be active, but he could not. He never got fidgety or anything like that. With the disease, they start to lose their ability to swallow. Eventually we had to have a PEG inserted and fed him intravenously through the PEG. Having done that, we had him at home for the last year. He was really in a bad condition. He lost bodily control over his bowels and could hardly walk, and then finally he finished up having a brain haemorrhage. We took him to the hospital where our neurologist was looking after him and he was given painkillers, morphine and what have you. We kept saying to the neurologist, “Peter, he is in pain.” He said, “But I have given him the

limit of morphine; I cannot give him anymore”, and he said, “But he is not in pain.” Well, I can tell you the last thing he said. He lifted his head from the pillow and said, “Bullshit.”

Five and a half weeks later Michael passed away.

Even more distressing was the evidence from Michael’s sister Katherine, who at the age of 25 was herself diagnosed as being gene positive for Huntington’s. She now lives knowing Huntington’s could strike at any time. Katherine says that she lives a pretty happy existence and is full of life. She told us —

I have Huntington’s. This is my greatest fear, to have to die in pain, because I have seen that and I do not want to go through that. That is why I am here today.

...

... everybody has the right to die with dignity.

Michael and Katherine’s biological father committed suicide when she was only six. The committee heard evidence from the State Coroner that at least 10 per cent of people who have committed suicide in WA had a terminal or debilitating illness. Katherine’s story was the most heart-wrenching experience of my time on the committee.

I believe the committee has produced a comprehensive report that deals with end-of-life choices. I believe the report paints a picture of what services are currently available for Western Australians at end of life. It finds there is a need for greater access to palliative care. The AMA estimates that only one per cent of the adult population would opt for voluntary assisted dying to be legislated. That means the AMA doctors would have to improve palliative care and end-of-life care for the other 99 per cent of the population. The committee is totally supportive of this position. Of equal importance, the report recommends a framework for voluntary assisted dying, along with the appropriate safeguards, which the committee considers would give Western Australians greater autonomy and assurance as they enter the end-of-life process.

As I said earlier, this has been an exhaustive committee process lasting exactly 12 months. I would like to praise the committee staff who on many occasions burnt the midnight oil as they processed a mountain of submissions that we saw tabled today and prepared for no less than 81 public hearings. I would like to pay tribute to the two principal research officers, Dr Jeannine Purdy and Mr Mathew Bates; research officers Catherine Parsons, Michele Chiasson and Marion Huntly; and the other administrative staff involved.

In closing, this is a report that I think is an excellent summary of all the evidence and data received by our committee. It recommends the state government put together an expert panel to come up with a framework to facilitate voluntary assisted dying. I urge all members to read the report in its entirety.

[Applause.]

MR R.R. WHITBY (Baldivis — Parliamentary Secretary) [10.35 am]: I rise to speak on this report. Freedom, liberty and individual rights are fundamental to our democracy. What could be more fundamental to individual rights than the right to choose not to endure the grievous and irremediable suffering of a terminal condition? As a society that rightly champions humanity and compassion, how can we stand in the way of those who want this choice? The vast majority of Western Australians embrace life and want to continue living for as long as possible. This is not about denying those who are prepared to endure suffering the choice to prolong their life. When all is said and done, this fraught and complex debate can be distilled to a simple and fundamental issue: the right of an individual to determine their own fate. We should never allow the choice of life or death to be made by the state. The choice of death over life or life over death, if that choice is ever to be made, should be made by the individual. Opponents of assisted dying believe that the state, and only the state, should be the final arbiter via laws that prohibit choice. I say that this choice should ultimately be made by the individual. Surely only those who actually experience intolerable suffering in the final inescapable decline of a terminal condition are truly able to make this decision. The experience of our committee was that those who lived through the suffering of their loved ones in their last days were more likely to support this reform. Time after time we also heard the words of those who have passed, through their loved ones, about the dying wish to end the suffering that they could no longer bear.

This was a tough committee to be on, but our experience as committee members was nothing like the lived experience of the hundreds of people who contributed heartfelt submissions or evidence in person. I want to thank everyone who offered their view or told their story. I know it was often difficult to do. I would also like to point out that although public interest will overwhelmingly focus on one aspect of this report, many findings and recommendations received the endorsement of every member. These relate to issues including palliative care and advance health directives. Recommendations on these issues are designed to improve the end-of-life experiences of thousands of Western Australians and I am confident they will find widespread community support.

I am proud to have been part of a committee that worked so hard and so well together. Our members came from both houses and from multiple parties. We were Labor Party, Liberal Party, Nationals WA and Greens members. We were cooperative with, courteous to and considerate of each other. We demonstrated the very qualities that the community says it wants to see in its politicians. I also want to thank our committee staff. They also heard or read every last heartbreaking piece of evidence, often several times over. They lived and breathed this for 12 months straight and they were amazing.

Although there were so many moments of emotion, one I recall vividly came not in a committee hearing or during a regional or metropolitan visit, but in the corridors of this Parliament. I bumped into a tour group that happened to be from Baldivis. It was a non-sitting week and I explained that I was not in the electorate because I was attending a meeting of this committee. One lady grabbed my arm and, with tears welling in her eyes, pleaded with me to support change. She explained how she had watched her husband die. It would be callous and inhumane for us to ignore her.

Thankfully, there are deaths known as “good” deaths, but there are also deaths that come with suffering. Many, many Western Australians choose to bravely cope with the suffering of terminal decline, whilst clinging to every last breath of life to the very end. That is a valid choice and a choice to be respected. It is their choice. Others who want to choose a different end of life should be just as entitled to their choice, too. Much was made during our committee inquiry of how, despite the very best of palliative care, a percentage of Western Australians still die with intolerable, irremediable suffering. The figure is disputed amongst doctors; we heard a range of figures from two, five, 10 to 30 per cent. Surely the figure is irrelevant. Surely we are not here to decide on an acceptable figure for suffering, if those who have to endure the suffering are not prepared to accept it. Even if it were just one person, that solitary soul is entitled to the right to choose not to endure intolerable and irremediable suffering, if it is their wish not to do so.

[Applause.]

Mr R.R. WHITBY: I respect all my fellow committee members, including, from the other place, Hon Nick Goiran, and I respect his views. He has strong, faith-based convictions, and I am sure he also claims ethical, legal, moral and medical arguments for the strongly held position he presents in his minority report. He has every right to his views, and I know there will be many Western Australians who passionately share his views. But what of other Western Australians? What of Western Australians who also hold passionate, personal views—those who believe passionately in the right to choose? Personal convictions are personal; everyone has a right to their own beliefs, but not a right to impose their beliefs on others. No-one would dream of imposing assisted dying on someone who did not want it. What, then, makes it acceptable to impose continued intolerable suffering at the end of life on someone who does not want it? We have to remember that this change would not be compulsory. It is not imposed; it is about choice and individuals’ right to determine how and when they wish to die. If that is a choice one decides to make, it is the most intimate and personal decision anyone could ever make. No-one—not those who sit in this place or anywhere else—should have the right to interfere in such a decision.

The experience in other jurisdictions with laws similar to those proposed in our report suggests that very few people would actually use this law; and, of those who would, not all would actually take that final step. The experience overseas shows that many seek the option to choose, without ever making the choice. The right to choose becomes a comfort—an option, if needed—and they pass without having to decide on that final step.

Finally, I return to where I started: liberty, freedom and individual choice—which, as it happens, is how every one of us in this Parliament may eventually vote on this matter. I believe this, rightly, should be a free vote, according to each and every individual conscience. It would be your choice and no one else’s—which, as it happens, is exactly what our committee finds should be the case for every Western Australian at the end of life.

I commend this report, its findings and recommendations to the house, and I also want to personally dedicate the report to my cousin, Darren Whitby, of Busselton, who at 50 years of age passed away quite recently from motor neurone disease. Thank you.

[Applause.]

MR S.A. MILLMAN (Mount Lawley) [10.44 am]: I also rise to make a brief additional contribution on the tabling of this report, and I acknowledge the contributions that have been made by my fellow members. I echo the gratitude to the staff expressed by fellow committee members.

I really only want to make three points: firstly, that it falls to Parliament to resolve this issue, and I am confident that this Parliament is up to that challenge; secondly, my own personal views on this issue, and how I arrived at being part of the majority in this report; and, thirdly, to implore fellow members, the media and the general public to look beyond the most animating issue of this report—that is, voluntary assisted dying—to a more considered

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analysis of the enormous amount of work the committee has done on issues such as advance care planning and palliative care, as outlined in chapters 2 and 3.

This is an incredibly complicated issue. It traverses party political divisions because it is fundamentally a question of philosophy. It calls on us to question our core attitudes to liberty and freedom, autonomy, free will, compassion and life. One need look only at the composition of the committee to see how lofty were the considerations we faced, so I start by paying my respects to my fellow committee members.

Throughout this inquiry, I felt keenly how new I am to Parliament. In fact, it was suggested to me on more than one occasion that, given the fraught political subject matter, this was a committee better suited to people at the end of their political career rather than those at the start, but I am extremely grateful that I had the opportunity to participate. As members are well aware, I am a strong believer in the fundamental importance to our society of parliamentary democracy, and this place has to be where fundamental philosophical debates take place.

Members will be aware that the Parliament of Victoria has, in recent times, debated this issue. I borrow from Hon Cesar Melhem, a member of the Victorian Legislative Council who, when considering whether this issue should be referred to the Law Reform Commission, said —

In my view sending the matter to the law reform commission is premature. A number of people in this house have said this is an issue for parliamentarians and that we should be doing the work. It is what we are paid for, so we should be dealing with these sorts of issues. I totally respect both sides of the debate. I respect those who argue against it and those who argue for it. It is an issue that requires respect. The intention of both sides is to preserve human dignity. No-one wants to see their loved ones suffer.

The first comment I make on this report is that this inquiry and the tabling of this report now creates the conditions in which that philosophical debate can take place in our Parliament in an informed way. I would add that, having regard to my fellow committee members, I have great confidence that the debate we have on any proposed legislation will be a debate of the highest standard. I am confident in saying that on the following basis: committee members demonstrated incredible fortitude and strength of character in not only engaging with the evidence and the witnesses in a compassionate way, but also tackling the difficult questions, working towards consensus where possible, and remaining true to their personal ethical and philosophical positions.

As a believer in parliamentary democracy, I recognise that we must protect the minority and prevent the tyranny of the majority. I echo the comments made by the member for Baldivis and pause to place on the record my particular respect and admiration for the voice of the minority in this debate, Hon Nick Goiran. The honourable member is eminently qualified to prosecute the case for the minority, and demonstrated throughout the inquiry both an adherence to his values and an intellectual capacity to prosecute the argument in opposition to voluntary assisted dying. I, on the other hand, have joined with the majority in supporting the recommendations in this report—a position not taken lightly, but one that sits with my personal values: values of freedom, free will, compassion, autonomy and respect.

Again, referring to the Victorian debate, an opponent of voluntary assisted dying, Mr Kavanagh, a former DLP member for Western Victoria Region, was reported as saying, according to my notes —

“The passage of this bill would have a wide range of profoundly detrimental effects. It would diminish the protection offered to the lives of all people that is provided by the law and the social attitudes to which the law contributes. As explained, the bill ... will allow people who do not genuinely volunteer to be killed. Even beyond that, the bill’s safeguards, although initially observed, would weaken over time. There are likely to be other long-term consequences that we cannot yet envisage. We can be sure that these consequences will be pernicious, because they will emanate from initiatives which, while nobly motivated, are wrong in principle. It is wrong in principle to deal with the problems of human beings by killing them.”

In my view, that characterisation by Mr Kavanagh frames the debate in the wrong way. What is proposed in this report, is not the killing of people to solve problems, but the provision of vital assistance to those people at the end of their life to alleviate intolerable suffering. Arguably, by this report, we are bringing into the open for a proper transparent debate two pre-existing well-known practices, one of which is no longer practiced openly these days, but has been touched on already by the member for South Perth. I label these two practices “don’t ask don’t tell” and “palliative sedation”. As to the first of these, there was more than enough evidence presented to our committee for us to reach the view that assistance is being provided to patients at the end of their life, but that this assistance, although arguably illegal, does not lead to any criminal prosecution. I call this “don’t ask don’t tell”. As a lawyer with a faithful belief in the rule of law, this is an intolerable situation. Bad laws should not be evaded and avoided; bad laws should be changed. Access to rights should be available to everyone equally, based on the premise that no-one is above or beyond the law. Middle class people in Cottesloe with longstanding relations with their family GP ought not have greater access to a peaceful good death than traditional owners living on country outside Kalumburu.

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Amber-Jade Sanderson; Mr John McGrath; Mr Reece Whitby; Mr Simon Millman

The second issue is palliative sedation. I was transfixed by this treatment when we first heard evidence of it. To me, this sounded exactly like what I had in mind when I thought of a good process of voluntary assisted dying. My concern with this treatment option is that rather than recognise the autonomy and self-determination of the patient, it required an assessment by the medical practitioner that the patient was at the end of life. A state that was described as being difficult to describe but doctors and nurses knew it when they saw it. Again, this is unsatisfactory. I recognise it is a valid treatment option, but it should be open equally to patients to choose this, as it is to doctors to administer it.

My third and final point is this: the committee undertook an extraordinary amount of work outside of the question of voluntary assisted dying. Many members focused their attention on the provision of palliative care services and advance care planning. The committee was greatly privileged to visit many facilities and speak to many palliative patients and providers—all members of the committee have spoken on this. Visiting services in Albany, Denmark, Derby and Broome, we travelled the length and breadth of Western Australia. My view is that Australia is incredibly fortunate to have one of the best palliative care systems in the world. Having said that, we have undertaken some excellent research and we have made worthwhile findings and recommendations. In particular, I commend recommendation 7, calling for more palliative care beds in our northern suburbs. This is particularly important for my constituents in Mt Lawley.

I want to touch on advanced care planning. We made many findings on current problems and issues with the advance care planning regime centred on low uptake and uncertain application. As a lawyer, I must confess my grave concern about the evidence we received that prompted finding 3. Through advanced care planning, and in particular advance health directives, patients can make their wishes about medical treatment clear and explicit. If patients take the effort to consider and outline their medical treatment wishes, those wishes must be respected in the medical treatment that patient receives. I will be keen to work with the Attorney General once the government responds to the first suite of recommendations contained in our report.

Let me finish by thanking a number of people. I echo the thanks of other members to our fellow committee members. It was a privilege and a pleasure to work with you. I also echo the thanks that have been passed on to the hardworking committee staff who toiled assiduously to provide the assistance committee members required. I thank the many constituents who visited my office, wrote to me and called to let me know their views. Democracy is about reciprocity. My job is to represent my community, and I can better do that when people engage with me as their elected member of Parliament. When this matter comes on for debate in this house, as it surely will, I urge members to consult with constituents to hear their views and input into this debate. This is a very difficult and complicated debate and we can serve our communities and the state of Western Australia by listening attentively to what our constituents have to say. I commend the chair of the committee for the incredible job she did in very trying and difficult circumstances, facing emotional, ethical and philosophical issues. The content of the report and the significant consensus reached on so many issues is a testament to the way in which the chair discharged her functions. Finally, I thank my family and friends with whom I consulted widely as I solidified my views on the recommendations made in this report. I commend the report to the house.