

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from an earlier stage of the sitting.

HON PETER COLLIER (North Metropolitan — Leader of the Opposition) [5.07 pm]: Before the debate was interrupted for question time, I was going through the “My Life, My Choice” report to identify issues that had been raised about the capacity of Western Australia as a community to provide appropriate palliative care. A number of recommendations in that report and the minority report collectively indicated that there are some serious deficiencies in that area.

I would also like to draw members’ attention to the report of the Ministerial Expert Panel on Voluntary Assisted Dying, particularly the very pertinent dot point under the heading “Guiding Principles” —

- People approaching the end of life should be provided with high quality care, including access to specialist palliative care, to minimise their suffering and maximise their quality of life.

I do not think anyone would disagree with that. It is an identification that we, as a community, must get the order right. I suggest that we must get palliative care right in the first place, before we can contemplate legislation like that we are discussing at the moment.

I would also like to draw members’ attention to the “WA End-of-Life and Palliative Care Strategy 2018–2028”. That strategy was referred to in both the reports that I have mentioned. The vision of the strategy is to improve the lives of all Western Australians through quality end-of-life and palliative care. No-one can argue with that. Under the heading “Why the Strategy is needed”, it states —

End-of-life care is care that affects us all and is not a response to a particular illness or condition. Everyone will die; therefore, the Strategy is relevant and important to all of us. Death is unavoidable; however, we can change the way we talk about/manage end-of-life, death and bereavement and the way we plan, care and support those who are dying, including those who are close to them, such as their families/carer.

It goes on to say —

Delivering equitable end-of-life and palliative care across WA is challenging. This contributes to the need for a strategic, integrated, coordinated and collaborative approach.

Particular challenges include:

- inequitable access to end-of-life and palliative care based on need, e.g. geographical isolation and population groups
- increasing complexity, e.g. ageing and growing population
- ad hoc integration of specialist palliative care into care for people with chronic conditions

I will briefly go through the overview of priorities —

1 Care is accessible to everyone, everywhere.

That is the first priority. It continues —

I have access to good quality end-of-life and palliative care, regardless of who and where I am, or how I live my life.

2 Care is person-centred.

I am seen as an individual, and I have the opportunity to be involved in honest discussions with those important to me about my care. My values, culture and spirituality are respected and taken into account when care is given.

3 Care is coordinated.

I receive the right care at the right time, in the right place, from the right people. My care occurs within a coordinated/collaborative approach, enabling care to be delivered seamlessly.

4 Families and carers are supported.

Those close to me and/or caring for me are supported and involved in my care. The contributions made by my family/carer are recognised and valued by those providing my care, including their need to be supported during and after my death.

5 All staff are prepared to care.

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Wherever and whenever I am cared for, all staff involved in my care have expertise, empathy and compassion. All staff provide confident, sensitive and skilful care, before, during and after my death.

Again, no-one can argue or disagree with the vision contained in that strategy. Whether we have achieved that at this stage, considering the strategy is from 2018 to 2028, is very debatable. Obviously, we would not have achieved it in the first 12 months of the strategy. Again, I emphasise the point that palliative care is an essential precondition for the end of life of an individual, and if we cannot provide extensive, comprehensive palliative care for all Western Australians, we should not be considering this bill.

I turn to other views from members of the community. As I said, I accessed the views of a number of people. I went to a number of hospitals and palliative care units and spoke to the specialists and clinicians. Those I spoke to, to a man or a woman, spoke of inadequacies with the current provision of services. I will draw from an open letter from palliative care specialists that I received from Dr Doug Bridge. The letter was written by 21 highly qualified Western Australian palliative care specialists, 16 medical specialists, four nurse practitioner specialists and a specialist pharmacist. The open letter states, in part —

The McGowan Government has invited public comment on its discussion paper Ministerial Expert Panel on Voluntary Assisted Dying.

We write as WA palliative care specialists whose vocation is caring for those who are dying. Between us, we have been privileged to care for tens of thousands of patients and their families. We would like to explain our position regarding the Government's proposal to legalise euthanasia. In our conversations with our patients, their families, politicians, and even our medical colleagues, we are concerned about the confusion and misunderstanding regarding euthanasia and palliative care.

The confusion starts with the language. The discussion paper uses the term “voluntary assisted dying”. This term is ambiguous. It could be used to describe palliative care: we provide assistance to people who are dying. It would be less confusing if the discussion paper were entitled Ministerial Expert Panel on Euthanasia and Assisted Suicide. The older term “mercy killing” has fallen out of use, but is actually a more accurate description than “voluntary assisted dying”.

The proposal to legalise euthanasia and assisted suicide involves a massive change in the ethics of our society. “Do not kill” is a foundational ethical principle which has been observed by every civilisation for thousands of years.

Euthanasia and assisted suicide are not medical treatments, and most emphatically not part of palliative care.

...

Most people want to die at home. In Perth we are blessed with an excellent range of palliative care services, whether the patient is in a hospital, a Palliative Care Unit or at home. Sadly, many Western Australians do not have access to these services.

Unlike euthanasia, palliative care aims to provide total care (body, mind and spirit) for patients and support for their families.

With modern medications and procedures, we can almost always control symptoms. In extreme cases, at the request of a dying patient and his or her family, we have occasionally used deep sedation to control symptoms that did not respond to the usual treatment.

Rarely, a patient will say to us, “doctor, I just want to end it all”. Contrary to popular opinion, the reason for such requests is not pain, but despair and loneliness also called “existential suffering”. Euthanasia is not a treatment for despair and existential suffering. Provision of holistic care by a skilled interdisciplinary team of health professionals enables patients and families to acknowledge and attend to distress within themselves and their relationships. The time before death offers unique opportunities for psychospiritual growth and allows for healing even without a cure.

We agree with the discussion paper that, ***“too many Western Australians are experiencing profound suffering as they die. This is, in part, due to inequitable access to palliative care”***.

According to the parliamentary records of 3rd April this year, Western Australia has the lowest proportion of specialist palliative care doctors of any state in Australia. We have 15 full-time equivalents for the state, less than one third the number required to meet national benchmarks.

According to the Honourable Jim Chown, whose motion was supported unanimously, WA needs at least another \$100 million per year spent on palliative care for staffing and education, in addition to funding for infrastructure such as palliative care wards and beds.

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We do not believe euthanasia or assisted suicide are solutions to suffering. We reaffirm our commitment to our patients: we will continue to care for you to the best of our ability, guided by your choices, but we will not kill you. Although we work in a variety of institutions, these opinions are our own and not necessarily those of our employers.

In addition to that, I have had several meetings with the AMA. It recently released a survey of in excess of 1 500 doctors. The results of that survey are quite compelling. I will not go into the details of the bill at this stage, but suffice to say that should the bill pass the second reading stage, I will spend quite a considerable amount of time in the Committee of the Whole House dissecting particular clauses—that is on the assumption that it passes the second reading. Having said that, the AMA has raised a number of issues, both with palliative care and also the safeguards contained in the bill. I turn to the question about palliative care in the survey provided. The AMA asked —

Do you think that all patients should be offered accessible palliative care prior to, or at the same time as VAD?

Ninety-one per cent said yes, six per cent said no and two per cent said not applicable. The survey said —

Bottom line: Overwhelming majority—palliative care must be accessible, both financially and geographically, and delivery must be timely.

Another question was —

Do you think that the State Government should provide special support to patients outside metropolitan areas to ensure there is equitable access both to healthcare and to VAD services as part of the VAD Bill?

Ninety per cent said yes, six per cent said no and five per cent said not applicable. Beyond those survey results, the document states —

The AMA (WA) advocated for significant increases in spending on palliative care in WA, long before the debate on voluntary assisted dying (VAD) began. Our repeated calls along with those of others in the sector, have gone largely unfulfilled by governments of all political persuasions. However, on the eve of the State Budget 2019–20, the McGowan Government announced a \$41 million increase for palliative care and end-of-life choices—spread over five years. With \$5.8 million of that funding earmarked for end-of-life choices, this package brings the total investment by the State Government for palliative care services over the next four years to \$206.2 million. This is around a third to a half of what we are told we should have.

For example the University of Notre Dame’s Chair of Palliative Medicine Research Professor David Kissane AC says WA needs an additional \$100 million a year spent on palliative care over and above the circa \$50 million allocated per annum.

It has been reported that Western Australia has:

- the lowest number, per capita, of inpatient palliative care beds in Australia;
- just 15 full-time equivalent palliative care specialists, when we are in need of 50 or more to match Victoria per capita; and
- just one in three Western Australians needing palliative care get timely access to these services in the format of their choice.

It is therefore disingenuous to talk of removing suffering, unless we also fix palliative care. We know that most patients will never access VAD. However, most will need palliation, including those who do want VAD.

While GPs form the backbone of palliative care services, they are often reluctant to become involved without the eco-system of back-up that palliative care specialists and community nurses provide. As a result, the regions are especially impacted by the lack of adequate palliative care services.

The WA Palliative Medicines Specialist Group outlines specialist support in the regions:

- Pilbara: one visit a year;
- Kimberley: six one-week visits per year;
- Geraldton: 10 single-day visits per year; St John of God Hospital Geraldton offers in-patient care at an eight-bed hospice for both public and private patients.
- The Wheatbelt: 12 single-day visits per year;
- Kalgoorlie: one day per month;
- Esperance: once every three months;
- Bunbury: two specialists run a 10-bed hospice and an outpatient clinic;

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- Albany: one palliative care physician funded for six hours a week, with only three hours a week to run an outpatient clinic. Albany Community Hospice is an eight-bed in-patient palliative care service open to both public and private patients.

One of the key concerns is ensuring that long into the future, decision-makers do not view VAD, even subliminally, as more cost-effective, practicable or indeed more compassionate than the adequate provision of palliative and other care services. Properly funded palliative care will continue to serve most patients with terminal conditions very well, and VAD should never be discussed with a patient without the availability of palliative care and other management options being assured first. Patients may not want palliative care, but they certainly need to have that option accessible and it needs to be the government's priority.

That is quite compelling, particularly those figures that show in some instances in the rural and remote areas of the state people have access, if they are lucky, to one palliative care specialist a year.

There are a number of other examples of the lack of palliative care facilities. In summary, the points made in the reports, the palliative care strategy and the work done by government indicate that palliative care facilities throughout Western Australia are lacking. In a nutshell, the issues are such that access is even further limited in rural areas and almost non-existent in remote areas. For example, in its submission, the WA Country Health Service told the Joint Select Committee on End of Life Choices that there is limited oversight, coordination and governance of medical palliative care services across its services. This, together with the barriers to access across the state generally, must be addressed by the state government. I acknowledge the \$46 million that has been put towards palliative care and the \$17 million that has been added recently. Quite frankly, there is still a parlous lack of palliative care resources across the state; that is in both the metropolitan area of Western Australia and in the regions.

According to WA Health, public hospices usually accept patients with only very short life expectancies. The average length of stay for a patient is only 10 days. Patients, regardless of their condition, expected to live for many weeks or longer may not be accepted because they will block access to the beds. The number of hospice beds required requires a high level of patient turnover.

Palliative Care WA, call logs and other evidence suggests there are a number of people for whom existing services cannot meet their needs. They are not yet close enough to death to qualify for hospice care, but challenging health or family situations mean they are unable or unwilling to receive palliative care in the home or other community settings. They will likely be accommodated in hospital wards or aged-care facilities. There is no obvious or agreed solution to this problem. Options include the development of intermediary stages or longer term hospice facilities; increasing the capacity in existing hospices to ensure there are enough beds; and developing new hospices in geographically dispersed areas outside current localities with a high concentration of hospice beds.

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

I feel that the evidence presented and tabled in this chamber is compelling in that palliative care facilities are simply inadequate in Western Australia. I do not want it to be seen as an option between euthanasia and appropriate palliative care. I would like to think we can have both so that if someone is at the point of their terminal illness where they cannot think of an option, at least we know that we provided that individual with the care, support and mechanisms to ensure that they had the appropriate mindset to make that decision, and not before. Can we really say at the moment that we are in that position? As I said earlier, can we say to terminally ill people in the Pilbara, the Kimberley, the midwest, the goldfields, in the south west in particular, and in the northern suburbs of the metropolitan area that we are doing all we possibly can to ensure they are surrounded by people who love them and that they are surrounded by clinicians in medical facilities who are appropriate to ensure their decision is based on that premise, and not that there is no alternative?

As a member of the Legislative Council for the North Metropolitan Region, a number of people have spoken to me about this. A number of people have also written, which I will speak about in a moment. A number of members in the other place spoke of personal experiences. When people speak or write to me, they will frequently—I can understand it; I am not offended—base their comments on the assumption that I do not understand and that I have no idea what it is like. Personally, I do not; I simply do not. I do not understand what it must be like to have a terminal illness. But I have experienced it. I do know what it is like to surround someone you love, and no matter what you say and do and no matter how much you love them, you cannot do anything. In both instances, those two very important people in my life never, on any occasion, expressed a desire to end their life. They were fortunate because they were surrounded by the extraordinary love and affection of family and friends but also extraordinary medical facilities.

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My father passed away on 11 September 2014. He had chronic obstruction of the airways. That meant that ever so gradually, his capacity to breathe diminished. He used to get chest infections, and pretty much for the last two years of his life he spent his time in hospital. We knew the end was coming. It was not regarded as a terminal illness, but we knew that his tenure on this earth was limited. He was the most wonderful man. We loved him so much. On the night before Father's Day that year, they called us into the hospital. He had another infection. They told us he was going to go within the next couple of hours. It was really, really difficult because I did not want to watch my father die. We had surrounded him. The next day, Father's Day, he had resurrected. When he woke up the next morning, we had the best day with that man that one could ever imagine. He was the most extraordinary individual. He joked and laughed; he was everyone's friend. He communicated with us and then, at the end of that day, he slipped out again. For three days it was very difficult because he was unconscious. The staff at Sir Charles Gairdner Hospital were phenomenal. We were asked whether we would like to go to the Lotus Room. I do not know whether anyone else has been to the Lotus Room, but it is so special. It is a palliative care facility. He went there because he was at the end of his life. As soon as they say "palliative care", it immediately indicates that he is about to go. That started it off again. We had three wonderful days with him. We were all ready and he was ready to pass away, but the manner in which my father drew his last breath was as dignified as anyone can imagine. It really was dignified. I love him so much and I miss him so much. I hate the fact that he died, but that he died in the way that he did gave us some comfort.

I am not quite sure whether I will get through telling members about the second person but it is important that I talk about her. I lost my soulmate on a cold June morning in 2009 after she had been diagnosed with multiple myeloma four years prior. If members know anything about multiple myeloma, they know that it is one of the most hideous forms of cancer one can imagine. She underwent full blood transfusions and by the end, she was having them every few months, which in themselves were extraordinarily painful. I had just become a minister and I had mixed emotions; it was a terrible time. I would leave here to visit her. More often than not in her last 12 months she was in either St John of God or Hollywood Private Hospital. A lot of the time she was unconscious, but I would lay there with her. She never once indicated any desire to go early. She was surrounded by a wonderful loving family and magnificent health facilities in the palliative care unit. She was the most beautiful woman in the whole wide world. Towards the end, she came good. Three weeks before she passed away, we were sitting there and it was the first time she showed any emotion. She said, "This isn't fair. But I wouldn't change a thing for quids." The last few weeks were traumatic because we knew she was going. We had been told that she was going and that it would be only a matter of weeks. As I said, she slipped away on a cold June morning and the world lost the most beautiful woman in the whole wide world. She had magnificent care during that time. I personally saw the staff afterwards and both the family and I sent them flowers. In a very unfortunate situation, she was one of the fortunate ones because she had the care and support that a lot of people do not have access to. It really pains me that we as a society are not talking about an alternative to death to support someone through the process as much as we possibly can. I am not saying for a second that anyone in this chamber does not want to do that, but we simply do not. The evidence I have provided over the last half an hour and that members have read is stark evidence that we have to do so much more to ensure that what my Cherry and my father were provided with is provided to every Western Australian. Until we reach that position as a community, I do not see how we can go down the path we are considering today.

I will talk about one of the most vulnerable groups in our community—I have talked about it indirectly—which is Aboriginal people. As I have said on numerous occasions, I am a proud Kalgoorlie boy. I grew up with the Wongi people and I have deep personal regard for Aboriginal people. It pains me that one of the groups that is very vulnerable and susceptible to a lack of palliative care facilities is Aboriginal people. The former government put in place regional services reform and the current government has continued it. I would like to think that the quality of life of Aboriginal people in remote communities will ultimately benefit significantly, particularly in the area of health, but we are nowhere near that at the moment. I draw on the comments of an Aboriginal man, Senator Pat Dodson, who stated —

First Nations people do not enjoy the same quality of life in this country at every stage of their existence, as shown in the national figures. In the womb, a First Nations child is at higher risk of contracting life-threatening bloodborne diseases. Last year, six First Nations babies died of syphilis. Our children are more likely to be diagnosed with chronic health conditions such as type 2 diabetes. They are at greater risk of contracting meningococcal and rheumatic heart disease.

...

In the Kimberley region, where I come from, the suicide rate is the highest in the world.

By what most Australians call middle age, many First Nations people are already living with kidney failure, without sufficient access to dialysis. The burden of disease and disability in First Nations communities is far higher than it is in the general population. First Nations people are more likely to live with a severe or profound disability. They also die younger. On a national basis, First Nations men can expect to live to

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an average age of 69, while non-First Nations men can expect to live to 80. First Nations women can expect to live to an average age of 73, while non-First Nations women can expect to live to 83 ...

With so many of our people suffering complex health conditions at an early age, there is a desperate need for culturally appropriate palliative care services in regional and remote areas. A review recently commissioned by the Australian government confirmed that more needs to be done to ensure that First Nations people are receiving palliative care within their communities.

Where First Nations people are already overrepresented at every stage of our health system, it is irresponsible to vote in favour of another avenue to death. Paving the way for euthanasia and assisted suicide leaves First Nations people even more vulnerable, when our focus should be on working collectively to create laws that help prolong life and restore their right to enjoy a healthy life.

He concludes —

In the broad sense, we are part of a common humanity. If we give one person the right to make that decision—that is, to assist in committing suicide—we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected.

I could not have said it better myself. In addition to Senator Dodson's comments, I draw from one dot point from the 2016 review of palliative care, which was done for the Department of Health. It states —

There remain significant barriers to access to palliative care services for a number of people within the population, particularly for Aboriginal and Torres Strait Islander peoples. While some progress has been made in raising awareness of palliative care services in culturally appropriate ways, the cultural security of palliative care services varies significantly. The Strategy does not focus on groups which have traditionally not accessed palliative care services; developing culturally-specific activities to address the needs of Aboriginal and Torres Strait Islander peoples may help to improve access to services for those who need it.

Having said that, I do not want to continually repeat myself. I will conclude with some figures but, suffice to say, I am conscious of the fact that the government has provided additional funds for palliative care. I am concerned, first, that the amount is insufficient and, based on the comments that I have articulated today, it is seriously deficient; and, second, it is sporadic at best and non-existent at worst. We cannot go down the path of looking at the alternative before we provide that option. Comprehensive palliative care is an absolutely essential prerequisite before any consideration is given to voluntary assisted dying or euthanasia.

To conclude, I have listened to the views of the community. I am very conscious of the views of the community as per published opinion polls. An opinion poll of 656 people was printed in *The West Australian* of 26 August and it revealed that nine out of 10 of those polled want euthanasia. I would be interested to know what question was asked on that particular occasion. Was it do you support euthanasia or was it do you support euthanasia before appropriate palliative care is provided? I would be very interested to know what that question was. Suffice to say, that view has pretty much been seen across the board with published opinion polls. I have received in excess of 1 100 emails, most of which were received in the last few days after our phone numbers were published. Around three-quarters of the writers said no. It has gone down to about two-thirds saying no now, with people being prompted into action. Of those 678 people who wrote to me, 525 were against and 53 were for the legislation. That is completely filtered. It is unambiguously truthful. That is where it is at. That is what I have been provided with. That is a consideration of course. I also acknowledge the fact that publicly presented polls consistently show that the majority of people are supportive of the legislation. I am conscious—I will repeat this—of whether the questioning in that area necessarily provides the option of palliative care. I feel very strongly about this. I am very conscious that a significant number of people with a terminal illness desperately want this legislation, along with a lot of families and older people. I am also conscious that a lot of people who are in that frame of mind do not have the adequate palliative care that they so richly deserve. Until we as a society and until this house can say that every single Western Australian has appropriate, comprehensive palliative care opportunities, I cannot support this legislation, so I will not be supporting the second reading.

HON ALANNAH MacTIERNAN (North Metropolitan — Minister for Regional Development) [5.41 pm]: I have to say how pleased and in a sense surprised and almost a bit unbelieving I am to be here today and have the historic opportunity to legislate to give Western Australians control over how they die—to provide for our citizens the right to choose to have medical assistance to end unbearable pain and suffering at the end of their life. I have always supported this cause. I have always very firmly had the conviction that people should have this choice. It is essential for human dignity that each individual has the right to make that choice.

I have been involved with Dying with Dignity Western Australia and its predecessor, the WA Voluntary Euthanasia Society. I want to take this opportunity to really pay tribute to that group, which has been battling away at this for

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40 years. I acknowledge people such as Murray Hindle, who led the group for so long, and Dinny Laurence, who have really kept this cause alive.

I regret to say—it is to my shame—that until five years ago, I never made this cause a priority. I remember Hon Robin Chapple contacting me in about 2009 when he first started rounding up the numbers. I said that I would support a bill. I did not do anything to progress the cause, even though I felt very strongly about it. When I was travelling to Canberra one Sunday afternoon in 2014, I was reading an article in *The Monthly*. It was asking why this right for medical assistance to die was not legislated anywhere in Australia even though the cause had the overwhelming support of the public for many decades. It asked what that said about our politicians and questioned how disconnected they were from the wishes and aspirations and space where the community was at. I felt deeply ashamed because I was one of those people who supported it, but it was a complex and messy issue. We knew that the people who opposed it opposed it with such passion that it always became a complicated issue. I had not really pulled my weight in this regard during the many years I had been in public life. When I arrived in Canberra, I rang around and found that Richard Di Natale from the Greens and Sharman Stone from the Liberal Party were strong supporters of this cause, and together we became the joint conveners of the parliamentary friends of Dying with Dignity in the federal Parliament. We tried to explore what we could do in a federal sense to promote this cause. We did quite a lot of work highlighting the need for these issues and supporting the territories to have the right to determine legislation in that regard.

When I finished up in federal Parliament, I remember the then Leader of the Opposition, Mark McGowan, approached me and asked if I would be interested in coming back into state Parliament. I told him that he needed to know before he made the offer that I was very committed to this cause and I would want to pursue it if I got back into Parliament. He obviously had no problem with that. We saw a build-up of community interest in and pressure for action on this issue. In the lead-up to the highly contested 2017 state election, for the first time we saw many politicians getting off the super six and honestly answering how they intended to vote on legislation of this type. There was a big campaign by the Dying with Dignity group and also doctors for choice. Many people from both sides of Parliament, and often in very marginal seats, were prepared to stake out their position. I do not think any person was disadvantaged by supporting this cause during that election. It has been observed by many members that this was really the first election in which this issue was at play in Western Australia.

Having moved this legislation forward, our government has done the right thing. It has given the Parliament not only the right, but also the obligation to make a determination on this issue for the people of Western Australia. I understand and respect the wide diversity of views in this place. It is absolutely important that we vote on this legislation and bring this issue to a conclusion. That is what the community expects of us; it wants us to make a decision. We understand that with legislation such as this, there will be a great deal of scrutiny. We are all expecting that, and we think that is right and proper. At the end of the day, it is important that before the end of this year, we as a Parliament stand up and be counted, make a decision and vote on this issue. I hope with great passion that we make the decision that the vast majority of the community wants us to make.

We have gone about this process with great thoroughness and rigour. I was very impressed with the work of the Joint Select Committee on End of Life Choices—it was extremely thorough—and then the work of the ministerial advisory group and the decision to have a government bill to ensure that all the complex matters could be properly dealt with. As I said, it is now up to us as members of Parliament, as people representing our community, to make the decision.

Like the Leader of the Opposition, I believe in the sanctity of life. I think that is absolutely essential and is at the very essence of our civilisation. However, I truly believe that having a good death, to be able to face dying without fear, is integral to a good life. This whole legislative package is life-affirming. It is about giving people the opportunity to have the comfort that in those final days, they are not going to have a horrible exit from this world. To me, that is honouring life.

Quite rightly, we talk a great deal about palliative care services as part of the suite of end-of-life choices that must be available to people. The government acknowledges that the services are not perfect and that they are not always even across the state, but we rank well by world standards. There has been investment in this area. We also know that jurisdictions that have end-of-life choices legislation generally invest more in palliative care. We have acknowledged that all this examination of palliative care has highlighted some shortcomings in WA. We have invested an additional \$60 million to address some of those shortcomings. The critical issue in this state is that clear evidence exists that there are hundreds of cases each year of people who are beyond the reach of palliative care, not in a geographic sense, but because the nature of their condition is such that it cannot reasonably be alleviated by palliative care. Those stories abound. They abound in the reports that have been presented and they abound every time we have a forum. I have personally participated in 10 forums in the four or five months leading up to this legislation being introduced. Many cases that simply cannot be alleviated are listed in the report—for example, bone cancer, neurodegenerative disorders and many of the lung disorders. I note the Leader of the

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Opposition's very moving account of his father's condition. It is estimated that around 500 Western Australians are currently suffering in these ways. This is not just a theoretical problem; it is a real, present problem. No matter what we do in developing and expanding palliative care services, and as important as that is, there are probably 500 people, maybe more, in Western Australia at the moment who are suffering from conditions the pain and suffering of which cannot be alleviated by palliative care.

We know the terrible reality is that around 10 per cent of suicides in Western Australia, and indeed in many advanced countries, have been attributed to a person taking action to alleviate a terminal illness. We know from many of the stories from our constituents and matters on the public record that many people end their life early by suicide because they want to take action while they are still physically capable of doing that. Hon Robin Chapple will know well the case of Clive Deverall, who was head of palliative care in WA, and such a leader with the Dying with Dignity campaign early on. I remember Clive telling us how angry he was that action was not being taken, knowing that there were hundreds of people suffering in pain; we could relieve it, but we were not doing it. We then heard on election day that Clive, who had been diagnosed with a terminal illness, went to a polling booth at a school and then took his life. He shot himself. He shot himself because he wanted to do two things. He wanted to have control while he was still physically able, but he wanted to make the point that this was something that had to be dealt with. I hope that Clive, from beyond, and his lovely wife, Noreen, will take some comfort from the fact that his inspiration, his work and his advocacy have been part of a great movement that has led to the historic legislation that is here today.

After the dinner break I will talk a little about some of my personal experiences and some of the experiences of my constituents and people around the state. There has been some contention about a couple of aspects of the bill that I think are really important. One is the obligation of a doctor to set out all the options for a patient who has a terminal illness. The Victorian legislation contains a provision that prevents a doctor from raising this issue with their patients. I find it an extraordinary proposition that we would not want people to know what their options are. I think this is really underestimating the sense and desire of our community to be in control. To me, the idea that there should be an option there, but people are not allowed to talk about that option unless they have the knowledge, or indeed it might be the case that they raise it with a doctor, is a very unfortunate provision in the Victorian legislation. I urge members to think about this, to think about the importance of a person being given all options. I think it is thoroughly misleading to have a situation in which they have a doctor advising them about their options, but there is one that they are not allowed to tell them about. It is almost as if this is a studied misinformation campaign because presumably a person will take the view that they have been presented with all the options, but in fact one is missing. I know there is a bit of debate going on around that particular aspect, but I urge members to respect the right of people in the community to know what options will truly be available to them should we manage to proceed with this legislation.

One of the constant themes at the forums on voluntary assisted dying is that this legislation does not go far enough and that many people want to be able to make an advance health directive in the event that they are suffering dementia and are not capable of going through the process that we have laid out, which is underpinned by an active request. It will absolutely not be possible to do that. At the very heart of this legislation is that question of conscious choice. It is us saying that it is the person at the heart of this who must be the person who has the right to choose. It is not the doctor. It is the patient; it is the person whose life it is. Any advance directive would require intervention by a third person who interprets that advance directive and says that this is the point now.

Sitting suspended from 6.00 to 7.30 pm

Hon ALANNAH MacTIERNAN: I want to now go on and talk a little about some of the personal experiences I have had that I think illustrate some of the dichotomies and issues that we need to deal with. I will then move to the stories from people in my electorate and around the state who have contacted me.

When my mother died some 11 years ago on my birthday, it was the best present I could ever get, because I had felt so immensely guilty about her suffering. She had asked me many times whether I could kill her, because she was at the point at which there was no enjoyment of life whatsoever. Both physically and mentally, her life was incredibly challenging. There is no doubt that the pain, and the suffering in particular, that she was going through meant that this was a life of virtually no quality. On the other hand, my father-in-law came to live with us in his 90s during the last weeks of his life, to be at home surrounded by family. Even though his death was quite challenging—he had massively fantastic care by Silver Chain—I never got any sense that he would want that life to be finished early. People are different. It is very important for us to understand that this is about choice. If this legislation is passed, that choice will still be available to people.

In the last 20 months, I have watched two deaths very closely. One was of a very, very close friend of mine, Jennifer Harrison, who had been my very, very good friend for over 40 years. When Jennifer got her diagnosis of metastasised cancer some two years before, she made sure that every possible moment was as full and as rich

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as possible. She was someone who absolutely wanted to seize every opportunity that life still had to offer—to be surrounded by friends and family and to go off and have new adventures. But when the time came, when her pain was so great and her mobility had been so compromised, she had the benefit, again through massively excellent palliative care and negotiation with the palliative care service, of terminal sedation. I was with her for eight of the last 12 hours of her life, during that time when she was receiving palliative sedation. I am confident that those 12 hours were not a cause of distress for her and that she passed from life looking as fabulous and gorgeous as she always had. It was peaceful; it was a good death.

Some six months later, I was dealing with an elderly relative, and the story is the exact opposite. This was someone who wanted to die. She was in her mid-80s. She had stopped eating for quite some weeks—she was really just skin and bone—and she was kept on a regime of very light sedation in a nursing home for around 14 days. I watched her go through enormous distress. Every day I visited the nursing home I would ask them to provide more relief, but it was done in such a way that it just strung out her death for weeks. Her death was eventually caused by massive organ failure. This was not a good choice for her. This was no choice for her.

Some people say that we already have terminal sedation or palliative sedation, but that depends very much on what the doctor is prepared to do. What we are asking for here is that the patient, the person whose life it is, be the one who makes the choice—that they have the sort of choice that my wonderful friend Jennifer had to have a decent and not too protracted end to this experience, so that they are not kept for weeks in a state of semiconsciousness and with no real relief from that suffering. I know that many people have had a variety of experiences, but if we drill down, what they are telling us is that we need choice to reside not with the doctor, but with the person. That is the essence of this legislation. It does not mean that we are denying those people who believe that they want to fight on to the end and that there is dignity in that suffering; we want them to have that choice. We want everyone to be able to make those decisions for themselves.

I will spend most of the rest of my time going through some of the submissions and letters I have received in the last couple of weeks. As I said, we have run 10 seminars around Western Australia. Overwhelmingly, people have been telling us stories that reinforce this message that palliative care is not the solution for everyone—that there are many cases that are beyond the reach of palliative care. I will go through a very small sample, believe me, of stories from Western Australians, who are telling us why we have to get this right. Professor Ian Hammond from Subiaco said —

I retired from clinical practice as a Gynaecological Oncologist in 2012, and since then have been involved with the Federal Dept. of Health, Chairing national committees that have led to the renewed National Cervical Screening Program ...

In my 30 years as a Gynaecological Oncologist, there were several occasions when women who had end stage gynaecological cancer, and who had accessed Palliative Care, but were unable to get relief from intolerable symptoms, usually bone or nerve root pain, and asked me if there was anything that I could do to ‘end their suffering’. This request came from the women, not their relatives, and sadly I was unable to offer them anything apart from ‘terminal sedation’ which for many was just temporally inappropriate.

I fully recognise that Palliative Care services will provide relief for the vast majority of the WA community, but there are occasions, probably about 3–5% of cases, where Palliative Care cannot provide complete relief, and this is generally accepted by the specialist Palliative Care community.

...

There is a much better solution and I believe our society must be humane and treat ‘ourselves’ as well as we would treat animals who are suffering. We can, and must, do better. Currently we do not, but the VAD legislation once enacted will lead to a significant improvement in end of life ...

Wendy Hewitt has written to me. She said —

I watched my mother dying of pancreatic cancer and pleading with my father to end her life. You can just imagine what an impact that had on all of us especially my Dad. I realise that not everyone agrees with my stance, however as an active member of the Wembley Downs Church of Christ my experience is that many members of the congregation have already signed a petition to be presented to support the legislation. We believe this in line with the compassion of Jesus.

Trevor Bordas from Girrawheen has said —

My input to this debate comes from six years working in the aged care industry as a Carer. It was the most rewarding work experience of fifty years. In the six years, I was able to share with Residents and their families their end of life experience. Palliative care figures high in the debate. It has its place but is not an experience that defines a better exit to life. If we are all honest, voluntary assisted dying already exists in society, in a form I have witnessed. I have witnessed the end of life experience of perhaps

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one hundred people and in most instances it has been distressful to the individual and not deserved. In my own instance, I live with three types of cancer within my body, one of which is Stage Four and probably will be the cause of my eventual demise. I appreciate my life but do not want to experience end of life torment and fear that I have observed.

Helen Swale from Mosman Park says —

Many of us who support this end of life Choice have a story to tell as to why we do so, having experienced first-hand what it is like to see a loved one die a painful death despite the best that palliative care could offer. Here are mine.

My father, having been diagnosed with Motor Neurone, indicated to us in the family that at some point he would take his own life—at the time of his choosing. My mother did the right thing—got rid of the shotguns he hunted with and any drugs around the house as she tried to keep an eye on him generally. He had been a strong man physically and mentally and found the wasting of muscle, difficulty swallowing and lessening ability to perform basic tasks devastating as it robbed him of any quality of life.

He had asked a Canadian friend to bring a large bottle of aspirin when next visiting ... This childhood friend wishing to kind and helpful to his childhood mate innocently fulfilled that request. A few weeks later, my mother heard my father vomiting in the bathroom and discovered that he had mixed a large number of the pills in a glass with water which he stirred with a toothbrush and swallowed. He was rushed to hospital where he told medics that next time he would “do the job properly”. Well, he didn’t need to try as he’d done enough damage to end his life when re-admitted two days later and died two days after that. I wasn’t there but according to my mother, it was pretty awful.

Helen goes on to talk about her mother’s very painful death. She says —

I’m not afraid of dying but I’m very afraid of how I die. I don’t wish to go through what my parents went through and more importantly, I don’t wish for my children to have to see or experience anything similar, particularly when there is the possibility of doing things a better way. I wish to have Choice. And Choice is what we who support VAD are asking for.

Jeff Rose from Scarborough writes —

My viewpoint has been strengthened by the suffering of my 70 year old ... twin Andrew during the last years of his fight against cancer.

His medical treatment failed him as it was too late due to him being wrongly diagnosed with a primary lung cancer when he was actually in the grip of stomach cancer ... The outcome of this negligence was that treatment including removal of the lobe, chemo and radiation, found him free of lung cancer but a negligent delayed scan of his body found the source which was stomach cancer and by this stage he was too weak, depressed and disillusioned ... that he decided to hasten his own death at home.

He called in his wife son and daughter and told them of his decision to deny more rounds of chemo and radiation, then contacted Silver Chain who transported a bed equipped with a morphine pump to the lounge room of the family home where his wife had shifted her bed to and denied food and sucked ice blocks until he died an emaciated skeleton quite a few months later.

Andrew, his wife, children and grandchildren and myself suffered indescribable anguish at the spectacle of him fading away more each day over an extended period.

By the time Andrew had decided to take his own life he was too weak to do anything but his mind was still active to the end and he was acutely aware of not only his own suffering but the suffering of his loved ones.

Andrew’s family, my family and many friends as a result of suffering with Andrew support the VAD Bill and I ask that you also support this overdue humane legislation ...

Vivienne Overton of Carine wrote —

I watched my mother die slowly and painfully, although she asked many times why someone couldn’t help her end her suffering. I now have Stage 4 lung cancer which has metastasised into my bones and now my brain. So far the treatments I’ve been having for the last two years ... have helped enormously and no-one is prepared to put a time limit on my life span, but there IS no cure and it’s just a matter of time before I become severely incapacitated ...

Why shouldn’t I be able to decide for myself when I’ve had enough? PLEASE support the VAD Bill before the Upper House so that I, and those in my position, have this choice.

Yvonne Bowey from Kulin wrote —

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I have taken to writing this email as I feel so strongly about the urgent need for the VAD legislation ... I am currently living and breathing the palliative care system, with my Dad in a regional hospital in the palliative care room. This is on top of watching my Grandmother in Law, battle and lose the same fight recently.

The care that is being given to my Dad is fantastic, but it cannot keep up with his pain levels. We are constantly being told that he should not be in pain and the aim is to make him comfortable, but the medication is not keeping up. There is a constant demand for increased medication, which comes as a reaction to pain, not as a preventative. Dad is of very sound mind and it breaks my heart that he is begging to die, his last wish, and we cannot accommodate this. For someone who has worked and volunteered all his adult life, he deserves the right to choose to end his suffering.

And this is really what this is about—choice. When (and I hope sincerely this is a when), the legislation exists, people still have choice, whether to use VAD or not. Currently this choice is not available and so many of our loved ones are suffering needlessly. I am tired of legislation being enacted for the minority and not the majority.

Hillary Whyte of Scarborough wrote —

I am a nurse with seventeen years of experience in the field of oncology, Haematology and terminal care in a private hospital. I have witnessed so much grief around the manner in which many of my patients have died. I am sixty years old. I have nightmares about dying in a hospital where someone else controls my death. I beg of you, please pass the voluntary assisted dying laws.

Fiona Harris from Dalkeith wrote —

I was diagnosed with Stage 4 Bowel Cancer 4 1/4 years ago. Since then it has returned 4 times—most recently I was told this by my oncologist today. I am still hoping to beat this dreadful disease, but I watched my mother-in-law die from it some 7 3/4 years ago.

If and when my time comes, I want to be able to decide when enough is enough. Let me assure you it will not be a decision that I will take lightly, but having had the number of surgeries and chemotherapies that I have had, I believe it should be my right to be able to say when I do not want my life unnecessarily prolonged.

So I support the VAD legislation ... It has been well thought through by some of our finest minds, and already incorporates appropriate safeguards.

To be clear, this law is not about life and death—it just gives those who are already dying, and suffering more than they want, the right to choose a peaceful death.

Maureen Duckett from Greenwood wrote —

I have worked in a hospital. I have had family who have died an awful death—in hospital and in nursing homes. I would like to be able to decide how and when to die—I'm not asking anyone else to die—just me. I can't understand why someone I don't know would like me to suffer. So many people, a great majority, want this law to pass so I don't understand why some elected members put their reasons ahead of mine—they will be remembered for not taking any notice of their constituents.

Please vote for this law.

Trevor Hay from Nannup wrote —

I am a 66 year old, conservative voting atheist. I also have multiple myeloma ... an incurable blood cancer. 18 months ago I experienced a level of pain I never thought possible as a result of my cancer (which had 'eaten' my bones). I wouldn't want to live with that. A palliative care doctor prescribed a drug regime that had me in 'la-la' land. I wouldn't want to live like that. I don't think that anybody has the right to force me to do either if I choose to take an alternative route. That choice should be mine alone.

Brenda Cuthbertson of Trigg wrote —

After watching my father —

Die —

by starvation, as there was no other way for him to stop living. He had no quality of life, no dignity, was in constant pain and was going to get progressively worse. I would ask you to support this bill.

Jane Bell of Middleton Beach wrote —

Please support the assisted dying proposal. I am 58 years old and have progressive advanced breast cancer for which I have been undergoing treatment since 2012.

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I have been fortunate to be under the care of Professor Arlene Chan whose expertise has enabled me to live confidently and comfortably with the disease as it progresses. I still live an active healthy life cycling, walking, swimming, sailing and valuing every minute of my life.

My greatest fear is prolonged suffering with deterioration. It would be of great comfort to know that when the suffering from the disease cannot be contained, that palliative care will allow me to choose to cease ineffective treatment and choose a course of action that gives me control over the situation.

Please vote to introduce laws that will provide people with an incurable illness the right to choose assisted dying medication to avoid prolonged suffering which will ultimately result in death.

Honourable members, I could have gone on for hours with these stories; this is just a small sample of the stories that have come in. They clearly demonstrate the reality. This is not theory; this is the reality—that there are many hundreds of people out there each year who are beyond the reach of palliative care, no matter how much we invest in it and no matter how good our professionals are. More than 80 per cent of the people in our community are asking for choice—choice about their lives, not choice about anyone else’s life. I urge members to listen to this painful reality and dignify our community and give each and every one of our citizens the right to make that fundamental choice at the end of their life. Thank you.

HON SAMANTHA ROWE (East Metropolitan — Parliamentary Secretary) [7.55 pm]: I rise to make my remarks on the Voluntary Assisted Dying Bill 2019. I would like to commence my contribution to this debate by very clearly stating that I am in full support of the current bill that is before this place. I intend to vote for this bill when the time occurs, hopefully within the coming weeks.

It is my belief that a secular society should seek to alleviate suffering wherever it may exist. I also believe that no-one should suffer for somebody else’s beliefs. I think the debate in the other place was an example of parliamentary democracy at its best with, by and large, considered contributions, very insightful questions during the committee stage, and expert responses from both the Minister for Health and his advisers. It should also be noted that, for many of us who are fortunate enough to be elected representatives in this place right now, at this point in time, this will possibly be the most important piece of legislation that we will consider.

The bill provides a safe and compassionate approach to voluntary assisted dying and a workable legal framework that will address an issue that a majority in the community is asking for and has consistently expressed support for over many years. I will note the key elements of the eligibility requirements; I think it is important that we note and remember them. Firstly, at all stages, this is a voluntary process for people and health practitioners. The person must be 18 years of age or older and an Australian citizen or permanent resident who has ordinarily resided in WA for the past 12 months. The person must be diagnosed with a disease, illness or medical condition that is advanced, progressive and will cause death. The condition will, on the balance of probabilities, cause death within six months, or 12 months in the case of neurodegenerative illnesses. The person must be experiencing suffering that cannot be relieved in a manner that they consider to be tolerable. Eligibility will be assessed independently by two doctors, who must have completed mandatory training to understand the legislation, assess decision-making capacity, detect coercion, communicate with patients at end of life, and understand the patient’s palliative care options.

Under this bill, it will be a crime to induce or coerce another person to participate in voluntary assisted dying. The bill provides robust and rigorous safeguards to ensure that access to voluntary assisted dying will be for only those assessed to be eligible. The government will also provide an implementation phase for the law, which will take approximately 18 months to complete. It will enable the development of policies and protocols, and the establishment of a Voluntary Assisted Dying Board to ensure compliance with the law.

There are 102 safeguards in the bill. However, perhaps most importantly, voluntary assisted dying will allow for a person to make a choice and to have autonomy over their own deeply personal end-of-life decision. This can be discussed and disclosed with others, but, like all medical treatment for consenting adults in our jurisdiction, ultimately the only view that should be carried out is that of the patient. As the member for Morley in the other place stated, the days of “doctor knows best” are probably long gone. Beyond the ancient Hippocratic oath and its mantra of first do no harm, modern medicine and patient care has developed contemporary ethical frameworks that are more reflective of our longer lives, advanced medical practices and our prolonged decline in later years. Importantly, these frameworks and the practical clinical efforts that are made in someone’s final days are more often aligned to a principle of dignity and protection from undue suffering.

It is also important to note that sometimes no amount of palliative care will eliminate the potential for someone to suffer horrendously when a terminal illness has taken hold. However, most importantly, palliative care is not always a choice that patients wish to make when considering their own end-of-life choices. I would like to refer to a story by a palliative care nurse on the Go Gentle Australia website. It states —

As a palliative care nurse, I am asked to end a patient's life about twice a year—about 40 people so far. I consider it a privilege that these people felt safe and comfortable enough to ask me this difficult question. I have never done so as I do not think it is my place, I do not have the right medications and it is not legal.

I have cried with people that it was not part of the holistic care I could provide. Sometimes I remember the faces and situations of those requesting assistance. You never quite forget the yearning in their eyes. They in turn have often comforted me that I could not do any better for them. I do believe people should have end-of-life choices, such as Voluntary Assisted Death. We can and must advance our response to this issue, through discussion, open debate and compassionate laws.

I have spent 16 of my 36 year nursing career in palliative care. This includes international, interstate, regional, metropolitan, community and inpatient settings. I have been privileged to work in gold-standard palliative care teams, so the requests to end patients' lives were not related to gaps in service. Such gaps and lack of access do occur but that is not the issue at hand.

The truth is that even with the very best palliative care service in the world, there will be a certain percentage of patients who do not achieve a peaceful death.

I think 90 per cent of the time palliative care teams do a really good job of easing someone's physical pain. But it is very hard to relieve somebody of emotional or spiritual pain. Their level of suffering depends partly on their tolerance for their quality of life. A growing number of people are seeking alternatives, which I believe should be legal and regulated. I have also nursed the failed suicide victims seeking some autonomy with a terminal illness. Many first responders have witnessed both successful and non-successful suicides.

In my career I have seen a lot of community education about pain control and palliative care, but there has been little debate about voluntary assisted death. Palliative care teams shy away from talking about it, but it is time for a transparent discussion. Many other countries have achieved good, well-regulated legislation.

I have seen doctors increasing pain medication to ease the end of life. I have seen terminal sedation, and I have seen people withdrawing from food and fluids. There have been hundreds of peaceful meaningful deaths. But there are still a number deaths that have stayed with me because they were not peaceful. For these people, the ability to make a choice about when to die, and to do it on their own terms, would have made a huge difference.

The best end of life care I ever saw was the vet who compassionately put down my beloved dog, with dignity and compassion. Just as we plan for birth, there should be options for death, with well-regulated legal avenues that protect the vulnerable.

It is really important to note that there are times when the very best of palliative care is still not enough for some patients. That is what this bill is about. Clinical interventions and innovations have provided an almost unbelievable level of care and an ability to care, treat, sustain and, in many cases, prolong life. However, in doing so, we are acutely aware of many members of our community who are now kept alive only through substantial and sometimes very invasive clinical interventions. Often these instances are in contravention of prior desires or requests for how a person's death is to be approached. Let me clearly state that voluntary assisted dying is not a substitute for palliative care, nor is it an extension of palliative care. The bill before this house notes that voluntary assisted dying is proposed to be available to those with a terminal illness. That illness needs to be advanced and progressive and will ultimately cause death. Let us be very clear that this is for those in our community who will die imminently due to a terminal illness and no amount of medical treatment or intervention will reverse that prognosis. For some, it may well include palliative care, while for others it may not be a viable option due either to their own condition and circumstances or a very personal choice. Whether it is palliative care or voluntary assisted dying, we must retain the primacy of personal choice.

I do not think anyone during this debate has, or it is highly unlikely that they will, declined to acknowledge the very important role of palliative care as part of a modern health system. It is crucial. I think it is really satisfying to see that our government has invested in this area. It is critical. I note that apart from the \$224 million that has been provided for palliative care services, additional funding has been made available. In the 2019–20 budget, \$17.8 million is being invested to enhance palliative care services. There has been an additional 10 inpatient palliative care beds provided, a 15 per cent increase in metropolitan inpatient palliative care beds, \$6.3 million allocated to improving metropolitan and regional community-based services, and the provision of an extra 61 full-time employees in regional areas to support palliative care.

However, I think we as a society have to improve how we discuss death, because no-one wants to suffer needlessly or in a prolonged fashion. For an event that is probably more certain than taxation, often a psychological barrier

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appears when we consider the ways in which we may want to face death. I think this bill has created a really important community discussion, and it is inclusive of our parliamentary debate about the way we talk about death in our community. In conjunction with our current world-class health system—a system that promotes wellbeing—the effective and appropriate provision of palliative care and voluntarily assisted dying can provide for the two central desires that we all retain, I think, in our subconscious, which is to have a good life and a dignified death.

The work undertaken by the Joint Select Committee on End of Life Choices was exceptionally thorough. The many safeguards that have been recommended and put in place in this bill probably make it one of the most contemporary of its kind. Taken on the whole, Western Australians have expressed an expectation that the WA Parliament deals with this bill expeditiously.

In conclusion, I want to express my thanks to the joint select committee and to the Premier and the Minister for Health for their unwavering leadership on this issue, and for the progression of a key election commitment. I would also like to thank the many members of the community—representing patients, families, carers, clinicians and policymakers—who have contributed as a collective and a community voice in the process of developing this bill. The joint select committee heard from a huge number of people in our community, and, I think, in doing so, have formed the evidence base for a really modern, safe and sensible piece of legislation.

This bill provides dignity. This is a bill that is designed to reduce unimaginable suffering and give people a choice. This is a bill that allows us to make a choice, I believe, that is fundamentally human. I commend the bill to the house.

HON ROBIN CHAPPLE (Mining and Pastoral) [8.12 pm]: I rise tonight in support of the Voluntary Assisted Dying Bill 2019. I do so as the nominated lead speaker for the Greens WA, which is a position I find somewhat bemusing, considering we all have a conscience vote. As this is a conscience vote, I will leave it to my colleagues in the Greens WA to individually give their evaluation and commentary on the legislation before us. I support the voluntary assisted dying legislation on four fundamental grounds. Before I go into that, I wish to acknowledge former Australian Democrats member Hon Norm Kelly, who started this journey on 16 October 1997 when he introduced his first bill in this chamber, the Voluntary Euthanasia Bill 1997. Here we are today, some 22 years later, dealing with the Voluntary Assisted Dying Bill 2019. I thank Hon Norm Kelly for commencing the journey as we work toward its conclusion.

I will not labour long on the many reasons for supporting this legislation. I have participated in two second reading debates on this matter, and I am sure that if people want to hear my extensive views, they can go back to *Hansard* and read what I have said previously.

In December 2016, prior to the last election, a dying with dignity working group, with Liberal MP Tony Simpson, MLA, Hon Alannah MacTiernan and me, gave a commitment to jointly introduce dying with dignity legislation should we all be re-elected. The quote we came up with stated —

We really want to present a bipartisan view—a Liberal, Labor and a Green moving forward in something the public genuinely wants and is long overdue.

Unfortunately, as we know, Hon Tony Simpson did not get re-elected. An interesting point is that as there was no provision in the WA Parliament to jointly sponsor a bill, we decided that once we had to come up with a bill that we all agreed on, we would all attempt to introduce it on the same day at the same time and work out who was going to be the winner after that, so to speak. But it was a genuine attempt at bipartisanship.

Firstly, I believe this to be valid legislation inasmuch as it will give peace of mind and succour to some of those people who will face unbearable suffering at the end of their lives. I am led to this belief as a result of having watched my mother suffer a very terrible end-of-life journey, and I will talk more on that shortly.

Secondly, it will fulfil a goal of mine that I expressed in my maiden speech on Thursday, 4 June 2009, when I stated —

I intend to continue my support for the introduction of voluntary euthanasia legislation in Western Australia.

Thirdly, the Greens WA have an endorsed policy of supporting voluntary assisted dying, which is referred to as the Greens WA dying with dignity policy. Again, I will deal with this later in my contribution.

Fourthly, this legislation focuses on the desires and the will of the people we are put here to represent. This is again reflected in one of the views we as the Greens WA hold dear, and that is the notion of participatory democracy.

Starting with the fourth reason for supporting this legislation, I turn to two consistent polls that reflect the views of the constituents of the Mining and Pastoral Region in particular. The most recent one was done by West Australian Opinion Polls. In it, the Mining and Pastoral Region polled the highest support of anywhere in WA—84.1 per cent. It is a very small electorate in numbers, but when we consider that this is a country electorate that I represent, I feel duty-bound to represent the wishes of my community. It had the highest level of support and also, significantly, the lowest level of opposition at 10 per cent, with 5.8 per cent undecided. This polling result was a reflection of

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a very significant poll by Newspoll in 2009, which must be one of the largest polls that I have ever seen and which polled various states' positions of support for what was then classified as voluntary euthanasia, and what we now refer to as end-of-life choices, or, in this case, the Voluntary Assisted Dying Bill.

I refer to how we fared as a state. In Western Australia, 86.3 per cent of capital city voters, or 1 072 respondents, and 92.1 per cent of non-capital voters—the country voters—were in support of euthanasia. That is my electorate, and that is one of the major reasons I am supporting this legislation. When the WA votes were compared with the votes in the states of Victoria, New South Wales and South Australia, only one state in a non-capital environment outpolled WA in support of the legislation. Of all the states, WA has always been a most significant state in support of voluntary assisted dying. I think it is important to say that, and the reason I do so is that I received a couple of emails from people who lobbied me saying that the polling is all fake and all the rest of it. However, in my view, with two polls over many years expressing exactly the same numbers, and, in fact, if anything, with the slight diminution of the vote in WA in support of voluntary assisted dying, I think their views are a complete and utter furphy.

I will come to some of the statistics from the current poll. Support for voluntary assisted dying was above 80 per cent in every upper house region, with the highest level of support at 84.1 per cent in the Mining and Pastoral Region and the lowest at 80.1 per cent in the East Metropolitan Region; more than 80 per cent of those surveyed believe that people should have the option of a doctor assisting them at the end of their life; more than 70 per cent believe that, in isolation of all other safeguards, having two doctors assess a person is a sufficient safeguard, even without the other 101 safeguards contained in this legislation; 76.5 per cent expect their member of Parliament to vote in accordance with their electorate's majority support for voluntary assisted dying, while 17.1 per cent expect them to vote only in accordance with their own personal conscience; 94.8 per cent of the people who strongly support or support the Voluntary Assisted Dying Bill feel very strongly or strongly about the voluntary assisted dying issue; and slightly more than one in two people, or 52.4 per cent, said that they would be less likely to vote for their local WA member of Parliament at the next election if they vote against the Voluntary Assisted Dying Bill, regardless of which political party they are aligned with. Awareness of the Voluntary Assisted Dying Bill 2019 is extremely high at 90.3 per cent.

I have received a number of emails, as have all members. Since the introduction of the legislation, I have received 89 emails in opposition to the legislation, 18 of which came from Dr John Buchanan, the secretary of the Australian Care Alliance, and 44 in support of VAD legislation. I find it quite interesting that the emails we are receiving are not reflective of the polling in any way, shape or form. It is important to note that a significantly large number of emails that I have received were against the legislation.

The Greens WA adopted its Dying with Dignity policy in 2017. Basically, it sets the premise that the Greens WA seek to save and preserve life, but we do not believe in forcing people to prolong their life under conditions of suffering at the end point of life. When people have a terminal illness and are suffering to such an extent that they no longer wish to have their life prolonged, they should be able to seek a peaceful death under medical supervision with their family in attendance, or ask consenting medical practitioners to help them end their life. Clearly, as members will know, policies set out broad, overarching visions, and turning policies into legislation is quite often a complex and difficult process. In this regard, I think the government has done pretty well.

I was indeed honoured to be chosen as one of the members from the Legislative Assembly and the Legislative Council for the Joint Select Committee on End of Life Choices established by motion on 10 August 2017 by the Legislative Assembly. At this point, I would like to thank my colleagues who served on the committee and, like me, learnt so much from that process. Believe it or not, I went into that committee thinking that I was all-knowing, but I certainly was not. The committee members were Ms Amber-Jade Sanderson, MLA, chair; Hon Colin Holt, MLC, deputy chair; Hon Nick Goiran, MLC; Mr Simon Millman, MLA; Hon Dr Sally Talbot, MLC; Mr Reece Whitby, MLA; and Mr John McGrath, MLA. Although we might have had a number of differences, over that year-long process, we had a very collegiate relationship. I even remember giving Hon Nick Goiran a hug outside a pub in Albany, and I can assure members that there is a photograph of it as well! Anyway, it was a good committee. We were exposed to lots of things. We were offered counselling. Some of the things that we experienced did indeed touch me very deeply, and I know they touched other members of the committee. Certainly, a young lady who is in the public gallery today gave a very detailed presentation about the demise of her mother that took us all to a very emotional point, and I would like to thank that young lady.

We met a number of people who were on that end-of-life journey. We went out with Silver Chain staff and met people. I am reminded of Tex; I think I have mentioned Tex before. Tex was a grumpy old bugger from the Pilbara. Excuse me, but I think I can use that word in this context. Tex was very interesting. He did not want anybody fussing around him, but he had a major problem. He had incredible gout. His legs were in a terrible state and he had compression bandages around both legs. Silver Chain sent us out with people to guide us. The lady who went out with us was not Tex's normal person. Tex said, "Who's this woman?" and got all grumpy. She proceeded to

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remove his compression cast and worked on his leg, but then she could not figure out how to put the cast back on. Luckily, I have some engineering experience, so I stepped in and tightened up the straps and we got him fixed up. He grumbled about her and said, “Bloody politicians—even helping me.” Beside him on his little table was a block of iron. I said, “Tex, that’s a hot iron briquette from Port Hedland” and he said, “How do you know?” and I said that I used to work up there. Suddenly, Tex became quite effusive and we chatted about his experiences up there. At the end of the visit, he said, “I don’t like bloody politicians at all. Don’t like Labor, don’t like Liberal and those”—I will not use the expletive—“Greens I have no time for at all” and I said, “Hi, Tex; I’m a Green.” We kept in communication and when Tex passed away, which is what he was going to do, his friend who had been looking after him said that I should feel very proud that I had made an impression on him, not as a Green, but as somebody who showed some compassion, and that he felt quite good towards politicians in general after that.

I am also mindful of some of the horrors that we experienced. One woman who was in palliative care in Sir Charles Gairdner Hospital was a prisoner. Hon Colin Holt and I remember that to this day. As far as she was concerned, she was not going to die; she wanted out of there. She had just had both hips replaced and was not going anywhere. But at the same time, they had shackled her to the bloody bed—excuse my language. This woman, who could not move and was in the process of dying, was handcuffed to both the base and the side of the bed. We both went to some great length to rectify that situation. It was an appalling situation. Those are some of the things that we faced. I am standing here feeling quite emotional about that. It was not a good experience.

Hon Colin Holt: She has since passed as well.

Hon ROBIN CHAPPLE: Yes. The interesting thing in that case was that everybody knew that she was terminally ill, except her. She would not accept it. So these are the really interesting dynamics that occur.

Then we went to Albany, and we saw what was one of the best palliative care situations I think we have ever seen. The wards and the systems there were stunning. People could open the doors. There was no rail, so they could wheel the bed out onto the verandah, and people had a little garden around them. It was stunning. Then there was that movie theatre.

Hon Nick Goiran: I wouldn’t describe it as a movie theatre, but it was a room to lessen the impact for the patients.

Hon ROBIN CHAPPLE: That is right. They had beautiful scenes of forests and thing like that displayed on this giant wall screen. It was very passive; it was very good.

That was part of the experience on that committee. I think we learnt in all our different ways so much from that committee. Although there might have been different views on the outcomes of the committee, I believe that the committee worked exceptionally well, receiving some 700 submissions and holding 81 public hearings. I do not think there has ever been a committee that has done that many public hearings. Its final report, “My Life, My Choice” was laid on the table of the Legislative Assembly and the Legislative Council on 23 August 2018. The committee’s majority finding went on to form the basis of the government’s decision to draft the legislation we are dealing with here and now. This process was further enhanced by the establishment of the Ministerial Expert Panel on Voluntary Assisted Dying. This committee had a wide representation of people from all legal, medical and social backgrounds, including Malcolm McCusker, QC; Dr Penny Flett, AO; Dr Scott Blackwell; Dr Roger Hunt; Associate Professor Kirsten Auret; Dr Elissa Campbell; Dr Simon Towler; Kate George, an old friend of mine from the Pilbara; Fiona Seaward; Noreen Fynn; and my dear friend Samantha Jenkinson. Its report was finally tabled in Parliament on 27 June 2019.

I would like to mention two particular aspects of the bill before us. Key provisions of the Victorian legislation have already proven to be unworkable. Members are well aware that the Victorian Voluntary Assisted Dying Act 2017 commenced operation only a few months ago. It seems likely that there will be an attempt to amend the bill before this house by incorporating several provisions that appear in the Victorian act, but not in this bill as tabled. Some of these Victorian provisions are highly contentious. In particular, one such provision requires, or at least is being interpreted to require, that one of the two doctors assessing the patient must be a specialist in the condition or illness afflicting the patient. Another prohibits doctors from informing patients of the option of voluntary assisted dying. Victoria is the only jurisdiction in the world to enact such a prohibition.

I would like to bring to the attention of the house that the effects of these provisions have recently been subject to a report by Dr Rodney Syme on behalf of Dying With Dignity Victoria. Members may know that Dr Syme is a medical specialist with unparalleled expertise in this field. He has had 27 years’ experience in counselling people about end-of-life issues and has assisted several hundred. This year, he was made a Member of the Order of Australia in recognition of his work. In the opinion of Dr Syme, the immediate effect of the requirement for one of the assessing doctors to be a specialist is to seriously diminish the number of available doctors, especially when combined with the appropriate right to conscientious objection. He states categorically that this is having a disastrous effect on the implementation of the act. He explains that available specialists are hard to locate, especially in regional areas. That

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is why I come back to the electorate that I represent, the Mining and Pastoral Region, where we have virtually no specialists. He explains that available specialists are hard to locate, and that this creates significant delay in a process when time is critical in reducing suffering. The result is that people are dying before their assessments are completed.

It should be noted that these observations are based on careful documentation on the experience of patients since the commencement of the Victorian act. It is obvious that if these are the results of provisions in Victoria, they would be magnified many times over if adopted in Western Australia. Already, we have rightly had considerable public discussion over the need for more palliative care services in the regions, and in that regard, the limited availability of medical specialists in remote and regional areas has been highlighted. This is especially the case in the Kimberley, the Pilbara and the goldfields. I am personally aware of the shortfalls. It takes no imagination to see that if a dying person is required to see a specialist in the regions and of course is unable to travel, they will simply be shut out of the right to choose voluntary assisted dying, in stark contrast to those in Perth. This would be unconscionable and an outrageous situation. As far as the prohibition on raising the existence of VAD is concerned, Dr Syme states that this is clearly in conflict with medical ethics, which require the provision of full information regarding lawful treatment options, which is a serious inhibition of the informed discussion and consent. I add that it appears to be an extraordinary intrusion into the doctor–patient relationship and the performance by doctors of their professional work. It is very disappointing that the Australian Medical Association is not loudly opposing the provision in Victoria.

The second point I wish to briefly make, and has been talked about here briefly, is the particular importance of my constituents—the Aboriginal constituents. Some have suggested that the mere existence of such a law will have a negative effect on Aboriginal people accessing health services. That is demonstrated by the experience in the Northern Territory. This claim is not borne out by hard evidence; in fact, it is contradicted by it. The 1996 report to the Senate Legal and Constitutional Affairs Committee into the bill that was passed and became known as the Andrews act, considered the evidence about the operation over the Northern Territory Rights of the Terminally Ill Act. The report noted the following in paragraph in 5.65 on page 52 —

The Northern Territory Government denied that there had been any decrease in the use of medical facilities by Aborigines, and provided the Committee with statistics in support of this assertion. This information related to hospital separations, emergency evacuations to hospital from remote communities and non-emergency travel to hospital under the Patient Accommodation Travel Scheme. No clear decrease was shown in relation to any of these categories since 1995.

I seek leave to table “Consideration of the Legislation Referred to the Committee: Euthanasia Laws Bill 1996”.

Leave granted. [See paper 3267.]

Hon ROBIN CHAPPLE: Secondly, and finally, I now wish to talk about my parents’ death. My father died an average death—six hours. That is the average. He died on 11 November 1980 of myocardial ischemia—a heart attack. It took him six hours to die. I was 32 and he was 74. My mother, Dorothy Margaret Chapple, was born in the subdistrict of Stoke Newington in London in January 1914 and died on 27 July 1988 in Sir Charles Gairdner Hospital from a number of contributing factors. Death was not easy; it was over an extensive period. It was not just one illness that caused her death; it was multiple conditions. I was lucky enough because my employer at the time, BHP, gave me leave to come to Perth and I was able to stay with her as much as I could. Eventually, I had to return to the Pilbara and she passed away while I was not with her.

One of the things that my mother died of was aspiration pneumonia. Aspiration pneumonia is a complication of pulmonary aspiration. Pulmonary aspiration is when food, stomach acid or saliva is inhaled into the lungs. Food that travels back up from the stomach to the oesophagus can also be aspirated. The other point is general debility, a state of general weakness or feebleness, which may result in the outcome of one or more medical conditions that produce symptoms such as pain; fatigue; I can never say this word—cachexia—wasting of the body due to severe chronic illness; and physical disability.

She also had an unusual condition, which meant that whenever I met my mother, I had to wear a facemask. She had pulmonary tuberculosis. Pulmonary tuberculosis is defined as an active infection of the lungs. Pulmo is Latin for lung. It is the most important TB infection because an infection of the lungs is highly contagious due to the mode of droplet transmission. Her pulmonary TB led to her coughing up phlegm and blood, and led to her having constant fever, night sweats, chest pains and weight loss.

The other interesting point that led to her demise was that she had to have nasogastric feeding, which is being fed by a tube that carries food and medicine into the stomach. That in itself is identified as one of the causes of her death. Another contributing cause was a bilateral obstructive uropathy, a sudden blockage of the flow of urine from both kidneys. The kidneys continue to produce urine in the normal manner, but because the urine does not drain, the

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kidneys start to swell. My mother also had a number of unknown complications, possibly renal tuberculosis. She was 74 years old; I was 41.

I started this journey back in 2001, when I was first elected. It will give me great succour if we reach the third reading and I can stand in this place and say, “Mum, I did it.” Thank you.

HON DARREN WEST (Agricultural — Parliamentary Secretary) [8.42 pm]: Members, I have long been a supporter of the right to choose the time to end our life. I am unsure whether that is from growing up in a progressive family and a progressive household or from growing up on a farm where, as very practical people, we see farm animals put out of their suffering on a regular basis and I wondered why that courtesy could not be extended to people as well. In my inaugural speech in 2013, I made reference to things I would like to see achieved in my term in Parliament. One of those was something like the Voluntary Assisted Dying Bill before us today. This is a historic day on which members of both houses of Parliament will look back on their time in Parliament and remember when they debated this important bill. It will be a big change in Western Australia should it be passed.

I am a strong supporter of this legislation for three reasons. Obviously, firstly, from my personal view that I have formed over my life. Secondly, because of the very high level of public support that has been indicated by previous speakers. I suggest that across my area of the Agricultural Region, it would be in the order of four in support to one against. The main reason I think for me is for those people who are affected by a terminal illness, those who have had enough, those who want to choose to end their life because they no longer wish to suffer. This bill is about that choice. This bill is about compassion, kindness and love. It is about families and people suffering, staring down the barrel of a terminal illness, being able to have that conversation about when is the time to go, whether it is at a time of the patient’s choosing to end suffering or the time determined by the illness—that is the patient’s choice, in my view. It should be their choice.

I want to thank all the people in the Agricultural Region who have contacted my office. There have been hundreds if not thousands of people from my electorate and across the state who have engaged in this debate and chosen to email, write, call or drop into the office to share their view. I have not come across anything in my parliamentary career that has engaged the public as much as the Voluntary Assisted Dying Bill has. I note that there have been great levels of respect. The debate in the Assembly was dignified, as it has been in the public, and it has been respectful. It is very emotive and I cannot underestimate the importance of acknowledging everyone’s views, even if we might disagree with them.

We recently held a forum in Geraldton. I thank Hon Alannah MacTiernan and the member for Morley, Amber-Jade Sanderson, Chair of the Joint Select Committee on End of Life Choices, for attending that forum. The view of our community was overwhelmingly in favour to the point at which it was suggested that we could have taken the legislation further. We had some very heart-wrenching stories, particularly from a gentleman who was staring down the barrel of the end of his life and desperately wanted to have a say in the timing of his death. We heard stories from families who are watching and have watched loved ones suffer.

I will not go into detail about all the anecdotes we heard. They are all beautiful stories of love and kindness that people wanted to be able to share with their family members. I respect that not everyone holds the view that this legislation should be passed. I respect also that there will be those who will find fault with the legislation and disagree with the notion that people who are suffering should have the choice to end their life at a time of their choosing. I say to those people, “I respect your opinion as much as I do not agree with it.” I would say to those who are terminally ill and hold that view, “Don’t access voluntary assisted dying; that is your choice. That is the choice we propose. You can either access voluntary assisted dying or choose not to.” For me, that is the most important part of this legislation before us—it is about choice.

Members, I do not see a link between choosing to end your life at a timing of your choice and provision of palliative care. However, I have found that this debate has shone a very bright light onto palliative care provision. It has also turned up areas in my electorate and other parts of the state where we perhaps struggle to provide the level of care that we do in parts of the metropolitan area of the state and in the country generally.

I note that whenever voluntary assisted dying legislation has been debated around the world, there has been an increase in palliative care provision. We see that happening here in Western Australia. Once a light has been shone on that service, we have seen subsequent increases in funding of palliative care across the state. I certainly welcome that because it is a separate matter from voluntary assisted dying, but, naturally, palliation is required for people who are staring down terminal illness and facing the end of their life.

This legislation has been developed over the past two or so years. I acknowledge the extensive work that has been put into it, from the health minister right through to the Joint Select Committee on End of Life Choices. I acknowledge the tremendous amount of work that was done by that committee and also by the Ministerial Expert Panel on Voluntary Assisted Dying. Due to the fine work put in by those dedicated people, I am satisfied with the

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provisions of this bill and I will be supporting it without amendment through the house. The Agricultural Region and its voters want this bill passed, as does the broader community. I think the broader community is satisfied with the bill as presented.

People facing terminal illness often resort to other means of ending their life. I have talked extensively in this place about terrible examples of the lengths that people have gone to because they do not have access to voluntary assisted dying. The passage of this legislation will provide that opportunity, rather than some of the very sad and tragic ends that those facing terminal illness have availed themselves of. I acknowledge the work of Belinda Teh, who is in the gallery today, for raising awareness of the need for people to have the choice to end their life at the time of their choosing. Belinda walked from Melbourne to Perth to raise awareness of voluntary assisted dying. I also acknowledge organisations such as Go Gentle Australia and Dying with Dignity Western Australia, which have helped inform the community and make people aware of what is proposed in this legislation. I also acknowledge the work of Andrew Denton, who used his profile to show his strong support for the legislation.

There are many more reasons that I could give for why I would like to see the legislation passed, but I think I have given the basic idea of why I support the bill and why I support it in this form. I do think it will be a historic day when the vote is held. I sincerely hope members can see fit to pass the legislation, because if we do not pass it at this opportunity, with the bill having gone through the Legislative Assembly and come to us, there may not be another opportunity for many, many years. I think the community is ready. I think the debate has been mature, respectful and dignified. There is no doubt in my mind that it is time we gave members of our community the choice to end their lives at the time of their choosing. As members of the community, we face all kinds of choices every day. We make all kinds of choices about all kinds of things every day. It strikes me as odd that perhaps the biggest one of all is denied us, for reasons that I do not really understand. I do not understand why we cannot make that choice ourselves.

This is a once-in-a-lifetime opportunity. As I said in my introductory remarks, I think we will all remember the time that we were in the Parliament of Western Australia when the Voluntary Assisted Dying Bill was debated. I hope we will all remember the time that it was passed. In my view, this is an excellent, well-crafted piece of legislation that covers many of the concerns about the notion of voluntary assisted dying that have been raised through the committee and ministerial expert panel stages and by members of the public and members of Parliament. I think it strikes the very necessary balance between what is acceptable to the public and the Parliament, and covers off on the views of members of the Legislative Council. I commend the bill to the house. I certainly look forward to its passage. Thank you.

HON MARTIN PRITCHARD (North Metropolitan) [8.54 pm]: As we get older, we come to face death more often. Our parents die. I just want to talk very briefly about the passing of my parents. I was listening to Hon Robin Chapple and there were some similarities. In 2016, my stepmother passed away. Kit, or Catherine as I called her, because she was a real lady, was 92. When she was 23, she actually went into hospital with tuberculosis. Through the rest of her life, she worked very hard. She smoked a lot and she drank a lot, but she always faced life straight in the eye. Kit, or Catherine, went into St John of God Midland Public Hospital at the age of 92. Basically, her body was giving out. But because of her early experiences in hospital, the biggest fear for Catherine was actually being in hospital. She had some delirium, so when we used to visit her we would often try to convince her that it was a hotel so that she would not become so aggressive in her more lucid moments, which had shocked the family because of the fact that, as I said, she was a lady. This lady passed away in hospital with fear and anxiety. She would never have thought of taking advantage of voluntary assisted dying and would just try and eke out every bit of life that she could. Even in her darkest hours, she was still hoping to go home and resume her life.

Six weeks after she passed away, my father went into hospital. He had actually been in hospital eight years earlier—around 2008. He went into Royal Perth Hospital. He had treated his body quite harshly during his life. He was a bricklayer, very blond and very pale. He used to spend his days in the sun laying bricks, with a pair of shorts and a pair of thongs on—I think I have mentioned that before—and ended up with multiple melanomas. In 2008, he went into Royal Perth Hospital. It was the first time that a doctor had approached me to talk about palliative care. The reaction of the family was one of horror, because we thought they had given up on my father and that he would pass away. Indeed, he came very, very close. Again, his main aim was to try to continue living, which he did. He came out of hospital with about 20 per cent of his eyesight left, about 20 per cent of his hearing left and using a walker. He spent the next eight years—again, I have spoken about this before—with a quality of life that I would not have thought was tremendous. He used to look forward to one morning a week when I would take him to the casino. He and Kit used to enjoy a half day at the casino. I do not know whether I would have thought it would be a good quality of life, but in 2016, six weeks after my stepmother passed away, he went into St John of God in Midland with aspiration pneumonia. He was 87—he was younger than my stepmother. Again, all he wanted to do was to get out of there, come home and live life as much as he could, irrespective of my view on the quality of his life. Of course, he did not. I think they basically just continued to up his morphine and he passed away. He would not have taken advantage of voluntary assisted dying either.

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My father-in-law passed away in 2012. He had an inoperable brain tumour. I was lucky enough to be able to take about six months off work at the time and I spent time taking him to Subiaco to have his chemotherapy and radiation treatment to try to shrink the tumour. They were reasonably good times, funnily enough. There was a lot of pressure, but they were reasonably good times. My father-in-law was sitting at home with us one afternoon when he got up and fell back down again with a heart attack, probably because of the strain of the chemotherapy and the radiation. I look back on that and say, “Well, we had a reasonably good time leading into his death, and his death was quick.” I remember thinking at the time, although I did not say it to my mother-in-law, that that was a good death. I suppose most of us hope that we are not going to die a painful or a dragged-out death, but a quick, painless death, or to fade away while we are asleep. The fact is that sometimes death is good; most of the time death is bad; and sometimes death is horrendous. That is for multiple reasons, pain being one, but there are others. During this debate, many people have talked about being in the arms of loved ones, whether it be through the opportunity to do that with VAD, or whether that be through high levels of palliative care. The fact of the matter is that not everybody has a happy family. Some people dislike their families. Some people do not have families. Whether someone dies alone with a doctor under VAD or alone suffering, it is still going to be a bad death.

If a person is in great pain, the only thing that VAD will do is alleviate their suffering. I understand that, and I accept it. I think that this legislation has the potential to help some people—not that many, I do not think, but some people—who have the will to face death on their own terms as an alternative to a horrendous death, and I accept that. However, as I said, there is still going to be a lot of unfairness in the world. People are going to die when they should not die; people are going to die in pain. This bill is not the answer to everything, but I accept that it has the potential to help some people.

When this campaign started—that is really what has been happening over the last number of months; there have been campaigns—I was quite taken aback by the fact that the campaigns commenced prior to any bill being before the house. Prior to anybody actually seeing the bill, people were saying, “This is fantastic. I want voluntary assisted dying. It doesn’t matter what the bill says; I want voluntary assisted dying.” Others were saying, “It doesn’t matter what the bill says; we can’t have voluntary assisted dying. It’ll be the end of society as we know it.” I was quite taken aback by the fact that the campaigns started so early. I think that most people in the community are debating the theme rather than the bill. I ask members to understand that we have the responsibility to try to make sure that the bill will achieve the aims that it has been drafted to achieve. My concern is that people have entrenched themselves into a position without actually reading the bill. That has happened with the public as well. Even before this bill was before the house, people were saying that 88 per cent of the public want voluntary assisted dying. I do not know whether that is correct or not. It probably is, but it still does not alleviate us from the responsibility of improving the bill if we can, or if it needs it. I have drafted some amendments. I would not say that I am an expert in this area at all, and I will not be unhappy if the amendments get defeated, if that is the will of the house. But the fact is that we are actually debating this bill and should try to improve it, even if at the end of the day we do not accept those amendments because they do not make the bill better.

Before this bill was before the house, we started receiving emails. Hon Robin Chapple, who is out of the house on urgent parliamentary business, talked about receiving 80-odd emails. I think I have probably received 7 000 or 8 000 emails. When I first took on this role, I made the mistake of answering my own emails. I have seen the emails on both sides. I am not suggesting that the pro forma emails that I have received are not valid—they are. However, I must say that I have answered only the emails that I know have been written and that actually tell a story and ask me to respond. Those are the emails that I have responded to. I have met quite a number of people who have sent those emails. I apologise to my constituency: I have not responded to the pro forma emails on either side, mainly because they did not ask me for a response, which was a very happy coincidence.

With the polling, again, this has been a campaign. Normally, if one engages a pollster, they will say, “Tell me what answer you want, and then we’ll draft the question.” Now, again, I would imagine that these polls have some value. I concede that the majority of our constituents fear death and, if faced with a horrendous death, would like to have the choice under this legislation. But it does not alleviate our responsibility to try to improve the bill as best as we can.

Following on from that campaign concept—because it has been tackled as a campaign on both sides—there has been tremendous overreach in people’s claims. Someone will say, “Nevada, everybody dies and they shouldn’t”, and somebody else will say, “No, everybody should have that right.” There is tremendous overreach. It would have been nice if within the campaigns there had been a little bit more discussion to try to get to the position that I think we all want, and that is the best outcome for our community.

I do not see myself as a warrior on either side of this debate. I see my role as someone who is in the middle, with probably the vast majority of people who do not want to see people die horrendous deaths, but also do not want to devalue life. If we do our job here, I believe we can achieve both through this bill.

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For me, the biggest problem with this bill is the drafting. In a past life, I did a lot of drafting of industrial instruments. We always wanted to take the opportunity to do the drafting ourselves. The drafter has tremendous power in any negotiations, because they set the theme. The theme of this bill has been set by the people who have drafted it, and it should not be beyond us to improve it. As I said, I have proposed a number of amendments, and, again, if they do not get accepted, as long as it is the will of the house, I do not have a problem with that. I have endeavoured to address the areas of concern I have in the amendments I have proposed.

One thing that the Premier said that struck a chord with me was that he believed that this was really a bill to facilitate death or death rather than life or death. If that is the case and we are talking about an elderly person who is going to die anyway but might have the choice of dying a couple of months earlier rather than having two extra months of life that would be fairly horrendous, I do not have a particular concern with that. I know there are moral issues, but I do not have a particular concern with that, if that is the person's choice.

Hon Nick Goiran: Honourable member, will you take an interjection?

Hon MARTIN PRITCHARD: Certainly.

Hon Nick Goiran: I hear what you're saying but the concern I have is what happens if the diagnosis is wrong.

Hon MARTIN PRITCHARD: That is exactly where I was going. One of the concerns I have is that to make it an argument of—for want of better wording—death and death as best we can, we have to try to get the prognosis right. That is not going to be 100 per cent. There will be mistakes; I understand that. But we want to try to get the best prognosis we can. I understand the difficulties in the regions, but I cannot believe that it could be appropriate for a person to say, "I'm going to die in six months; I should take advantage of voluntary assisted dying", based on the advice of a general practitioner. With all the respect in the world for general practitioners, there are some who specialise, but the vast majority are the doctors down the corner that people go to for some cough medicine. The vast majority are generalists. It worries me that, because of the issues and problems we have in the regions, we are going to say, "Okay, it's a long way away so let's just allow general practitioners to determine that a metastasised cancer is going to cause death within six months." I do not think I would be prepared to accept that as a prognosis.

One of my proposed amendments addresses one of Hon Robin Chapple's fears and proposes that one of the doctors should hold some specialisation in the area that is the subject of the application. I actually have no concerns whatsoever about the coordinating doctor being a general practitioner. Indeed, one would hope that it would be a general practitioner who has some relationship with their patient, would be able to observe any family coercion and would be best placed to determine capacity. However, I am not sure that a general practitioner in the back lots of the regions would have the ability to provide the most accurate prognosis possible when it comes to things outside their area of speciality. If members in this place determine that that amendment is not appropriate, that is fine; that will be the will of the house, and I am happy to accept the will of the house.

On a personal note, I went to a general practitioner—I will not name him—because, as members may notice, I am getting a little thin on top and I noticed a tingling feeling up there. I thought, "My dad had a lot of melanomas; maybe I should get it checked out." I went to my general practitioner, who I have been seeing for years. He said that there was nothing there, that there was no problem and that he could not see anything—fine. I went to a skin specialist the next day, because I did not accept that, and there was crystallisation; it was a pre-cancerous sunspot. It was probably nothing to worry about, but a general practitioner does not deal with dermatology often, and he completely overlooked it, even when I was pointing in exactly the right spot. That concerns me. Unfortunately, we had another bad experience with the same doctor nearly 20 years ago when he did not pick up on my wife's heart attack. He kept diagnosing her with indigestion and sending her home with Mylanta and so on. Eventually she was throwing up in the middle of the night; we took her to the emergency department and it was too late to repair her heart. Maybe we do not have great general practitioners in the northern suburbs! I do not mean any offence by that, but as I said, I do not think I would accept a general practitioner's prognosis that I have four or five months to live due to cancer. That is one area I have looked at.

The bill deals with coercion, but it is something on which we need to focus because, in my view, there can be many different types of coercion, including external, from the family, and internal—"I don't want to be a burden." There are many concerns in that area. I am also concerned about capacity. When I first read the bill, I thought, "Oh, 'capacity' means a patient has the capacity to make a decision." It is not really that. All that is required in the bill is that the person understands what is being said to them. If the doctor says to the patient, "You know that if you take this poison, you'll die", and the person says yes, that is capacity. That concerns me. I do not know a lot about mental illness; I have tried to get a little bit of information on it over the past couple of months, but I would have thought that if someone has just been given a prognosis of six months to live, there would be a good chance that they might be demoralised or depressed. It would seem to me that the doctor—I do not mind if it is the coordinating doctor—should have some responsibility, not just to ask, "Do you understand?", but to make sure that there is nothing treatable affecting the patient's decision. That is something else I looked at.

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I have in the past been involved in a lot of negotiations, and most negotiations are basically just discussions between people. Hon Robin Chapple will be disappointed with me again, because I have proposed an amendment to provide that the doctor cannot raise the issue of voluntary assisted dying. A lot of people still rely on a doctor's lead when it comes to their treatment. Again, if the chamber determines that that amendment is not appropriate, I will bend to the will of the chamber.

The Department of Health has people on staff who can go out to the regions to discuss all the options, but not be part of the decision-making process. For example, a senior nurse practitioner with broad knowledge in this area could go out to the regions and talk to the patient so that they know what options are out there. Something along those lines would certainly give me confidence that the patient is informed. I truly do not want to deny people who are suffering the right to ask for an early death. I do not believe this bill is an assisted suicide bill; it is still talking about death and death. I would not lose any sleep if someone determined that they did not want to live those last few months if it meant living in agony. Personally, I have fears about my own death. I do not think about it too often, but one of the fears is being unable to breathe, and there are a number of diseases that lead to that end. I might, rather than live with the fear, anxiety and pain, if there is pain, choose to access voluntary assisted dying. I am not opposed to the concept, but I am concerned that we made our decision before we got the bill and that the Legislative Assembly had no opportunity to debate in any earnest way any amendments. The only opportunity that members will have to look at amendments that may improve the bill will be in this place. If I am wrong and the bill does not need any improvement and I am very much in the minority, as I said, I will accept that that is the will of the chamber. However, I do not want people to just blind themselves. I do not think that my amendments are fantastic—other people probably have more expertise in dealing with amendments than I do—but I want people to look at any amendment that comes forward and make a determination about those amendments on their merit. I think at least one or two amendments will go through, so the other place will have to consider them anyway. Whether it considers two, five or whatever number of amendments, I do not want to destroy the bill, but I think there is an opportunity to improve it.

In my past life, I often did the numbers. I always thought that in this place it was easier to get 18 for a yes vote than it was for a no vote. A number of people are still undecided, but I think that the opportunity is diminishing. Although some members support the bill, I suggest that should not blind them to considering a good amendment, and I am not necessarily saying that mine are good. So, please, if you can keep your eyes and minds open to that, I would be appreciative. That is the end of my contribution.

HON PIERRE YANG (South Metropolitan) [9.21 pm]: Like I did in my first speech, I wish to begin my contribution on the Voluntary Assisted Dying Bill with the Lord's Prayer —

Our Father, who art in heaven,
Hallowed be thy Name.
Thy Kingdom come.
Thy will be done on earth,
As it is in heaven.
Give us this day our daily bread.
And forgive us our trespasses,
As we forgive those who trespass against us.
And lead us not into temptation,
But deliver us from evil.
Amen.

People may know that I am a Catholic. I believe in Catholicism and the Catholic teachings. My children go to a Catholic school. In essence, Catholic values ask people to be good people and to look after one another. With the house's indulgence, I am going to talk about my understanding of Catholic values and how they have shaped and influenced my position on this very important subject. I am not trying to preach Catholicism to anyone; I am merely detailing how I arrived at my position.

In my understanding, our Lord is almighty, all powerful, benevolent and infallible, because God is perfect; yet humans are not any of these and we are very fallible. In my view, God's teachings for us are the truth and perfect. His teachings were learnt and understood and translated by humans for humans so that the good news could be spread around the world in a form that humans could understand. At the same time, because we are fallible and our father's teachings have been translated by prophets who did their very best but who were constrained by the time in which they lived their lives, and by their social values and societal practices when they did their holy work, their translated teachings about our Lord must be viewed through the prism of the central teaching of our Lord—that is, to love one another and to take care of one another. Otherwise, we would be dogmatically following all the teachings in the Bible. We would still be condoning slavery because there are instructions for slave masters in the

New Testament on how to treat their slaves. We would still be treating wives as property in accordance with the Ten Commandments or having no divorce as part of normal Australian family law because anyone who divorces his wife and marries another woman or the man who marries a divorced woman commits adultery. There is severe punishment for adultery in the traditional teaching of Christianity.

I know that our Lord loves us and our Lord has mercy on us. All his teachings, however, must be viewed through the prism of the central teaching. I believe that our Lord loves us, that everyone of us is his son and daughter and he wants the best for us. Imagine this scenario? You are lying in your sick bed, suffering from a terminal illness and unbearable pain that cannot be managed by modern medical intervention. The question that springs to my mind is: would our Lord want us to suffer or would our Lord have mercy on us and want to help take away the pain and suffering? I believe that our Lord would prefer the latter. Our Lord is a force of good. Our Lord is a force of mercy. I am certain that our Lord wants us to have dignity, liberty and self-determination at any stage of our life.

Based on these strong beliefs, as a Catholic, it has been on the public record that I support in principle voluntary euthanasia for terminally ill patients whose pain and suffering cannot be medically managed. My position is understood through media reports, newsletters and things like that. However, this position does not equate with my accepting any view that is presented in front of me. As a legislator, I feel I have a duty to look at any bill that is presented to me, especially a bill like the one we are looking at now—a very significant piece of legislation.

I would like to take this opportunity to thank the hundreds of people who wrote to me, rang me and met with me to express their views both for and against voluntary assisted dying. In particular, I would like to mention Reverend Peter Abetz, Mr Carl Brown and Ms Belinda Teh for their time and for sharing their views. I think the debate has been conducted in a fashion that all of us as Western Australians can be proud of. We may not agree with each other on policy issues, but we are a mature democracy and we can have a robust but respectful contest of ideas. I am proud to be a Western Australian.

When I started to look at the Voluntary Assisted Dying Bill, which had been passed by the other place, I told myself to keep an open eye and an open mind, and to be very mindful of the issues raised by Parliament, the Legislative Assembly and people in the community. I watched all the members' speeches in the second reading debate in the other place. I watched the recording of probably half the consideration in detail stage in the other place. Of the many concerns raised with me, I have identified a few that drew my attention in particular. I wish to take this opportunity to go through them, and they are about coercion, psychiatric assessment and doctors raising the subject.

In terms of the concerns about coercion, from the outside, I was concerned that vulnerable people might be subject to coercion and choose voluntary assisted dying, as has been raised with me by people who met with me and wrote to me. However, after further research and study, I am satisfied that the safeguards contained in the bill are, on balance, strong and sufficient. The focus of the Voluntary Assisted Dying Bill is on it being voluntary. If there is any doubt of the voluntary nature of the request to access voluntary assisted dying, the bill requires the coordinating practitioner and the consulting practitioner to refer the patient to a health practitioner with relevant expertise for further assessment. If, after further assessment, there is still uncertainty about whether the request is voluntary and valid, the request will stop there; however, an application can be made to the State Administrative Tribunal for further assessment.

I have heard time and again about the hypothetical example of family members giving subtle messages to the elderly or the terminally ill that they are a burden and that it would be good for everyone if that person were to choose voluntary assisted dying. I understand the concept; I recognise that. At the same time, I also recognise that we do not live in a theoretical world. We live in the real world, which is full of uncertainties and full of risks. I do not say that in a flippant way. The reality is that we cannot ensure that there are zero fatalities on the roads, but we still use the roads for vehicle traffic. This is a fact of life, and I say that in the most sincere and genuine fashion. On balance, I am satisfied that my concerns about coercion are resolved by the safeguards contained in the Voluntary Assisted Dying Bill.

I wish to move on to the next subject, which is the psychiatric assessment. This is another concern, as the bill contains no requirement for a patient to obtain a psychiatric assessment to ensure that they are not suffering from depression, which would cloud their judgement to make an informed decision. From the surface, it looked to me to be a reasonable concern and a reasonable point. Nonetheless, I did further research and I am now satisfied that my concerns on this point are also resolved. According to the Voluntary Assisted Dying Bill, to be eligible for, or have access to, voluntary assisted dying, one must be assessed by a coordinating practitioner and a consulting practitioner as having decision-making capacity. I have strong faith in our medical profession. I have faith that it will do the right thing by Western Australians. As it stands now, in Western Australia, it is not illegal for people who suffer from a terminal illness and unmanageable pain to refuse treatment, food or water. In fact, as we have heard from the stories and testimonies, many patients choose that way to end their suffering. In many cases, it takes days, if not weeks, for their suffering to end. As I was listening to his speech in the second reading debate,

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Mr Simon Millman, of the other place, noted that there is no requirement for any psychiatric assessment for people who choose to end their suffering by refusing treatment, food or water. If we can afford people dignity and respect by providing voluntary assisted dying as an option for them to exercise so they do not have to go down the path of refusing food or water, which would cause them to suffer for days, if not weeks, as a society we should seriously look at that option and enact that. Based on this, I am having difficulty supporting the requirement for a psychiatric assessment.

I wish to move on to the last concern that caught my eye, which is doctors raising the subject of voluntary assisted dying. The Victorian model prohibits a doctor from discussing and bringing up the subject of voluntary assisted dying with their patient. Initially I was inclined to support or at least look at that as an option. If Victoria chose a certain path, we should probably look at it and seriously consider whether we should adopt it. Again, with further research, I found that Victoria is the only jurisdiction in the world that prohibits the doctor from raising the subject of voluntary assisted dying. Furthermore, as submissions to the Ministerial Expert Panel on Voluntary Assisted Dying pointed out, if the legislation is passed through Parliament, voluntary assisted dying will be a legal medical option and it should form part of a medical practitioner's general discussion with their patients about end-of-life care. I agree with this rationale, and I am satisfied that I can support the position that doctors should be able to raise the subject of voluntary assisted dying with their patients. This is not to say that doctors who have a conscientious objection to voluntary assisted dying have to raise this issue; they do not have to according to the current bill. A doctor who has a conscientious objection to voluntary assisted dying can refuse a request from a patient to access voluntary assisted dying. On this subject, I do not think that only doctors who object to the notion of voluntary assisted dying can be regarded as conscientious—that is, conscientious objectors. I agree with Canadian doctor Dr Sandy Buchman, who is of the view that those medical doctors, including him, who assist their patients to access voluntary assisted dying should be regarded as conscientious providers. I think he has a point.

I support palliative care and I support voluntary assisted dying, and I do not think they are mutually exclusive. As a matter of fact, I think they can work hand in hand to provide the best service that can be provided to other Western Australians. If someone chooses to exercise their right to access voluntary assisted dying, palliative care should continue. It is entirely possible for someone who has requested access to voluntary assisted dying to have their pain and suffering from their condition managed through palliative care in the meantime. That person may withdraw their request for access to voluntary assisted dying. It is entirely possible. We understand that the bill provides that a person who requests access to voluntary assisted dying can stop at any stage. It is entirely voluntary. At the same time, I am very glad that the McGowan Labor government is investing a record amount in palliative care.

After consideration and deliberation over the past several months, and very intensively over the past two weeks, I hereby declare my support for the Voluntary Assisted Dying Bill 2019 in its entirety. Let us not forget that there are severe penalties in the bill for people who do the wrong thing, with the maximum proposed penalty of life imprisonment. Opponents of the Voluntary Assisted Dying Bill argue that it is a dangerous step for us to take as a society. Some proponents contend that the bill does not go far enough to enable more people to access voluntary assisted dying. My view is that this is a conservative bill, and rightly so, because we are dealing with a very significant piece of legislation. We are dealing with a very important issue—people's end-of-life choices and their dignity and respect. I believe the bill has struck the right balance.

I would like to thank Premier Mark McGowan; the McGowan Labor government; the member for Morley, Amber-Jade Sanderson; and the members of the Joint Select Committee on End of Life Choices for their leadership and effort on this issue. I also acknowledge my learned friend Hon Nick Goiran for his work. I may not agree with the honourable member on this issue, but I absolutely respect him for his work, his work ethic and his dedication to something that I know he genuinely believes in.

The Australian community wants to give people who wish to access voluntary assisted dying the dignity and respect that they deserve. Support for voluntary assisted dying for terminally ill people was above 70 per cent in the 1980s and 1990s. A May 1996 Morgan poll revealed support for voluntary assisted dying was 74 per cent. The more recent polls, as we know, show us that support for voluntary assisted dying is well over 80 per cent and at times close to 90 per cent. I absolutely respect people's choice at the end of their life. It is an option not everyone will choose, and if they do not agree with it, they do not have to exercise it.

Debate adjourned, pursuant to standing orders.