

VOLUNTARY ASSISTED DYING BILL 2019

Second Reading

Resumed from 16 October.

HON COLIN de GRUSSA (Agricultural) [11.32 am]: When the house adjourned last night, I had been reflecting on some of the statistics in the region that I represent, the Agricultural Region, and talking about the demographics in conjunction with some polling, which I will go on to in a minute. I was saying that the demographics in the age group of 60 to 69 had increased in the period 2011 to 2016 by just over 3 500 people. Indeed, the number of people aged between 70 and 84 years also increased by 2 700-odd in that time; whereas, the population aged between 35 and 49 had decreased by 2 400 people. That shows there is an ageing population in that part of the state. One might imagine that an ageing population would reflect different views on issues such as voluntary assisted dying, but the polling in my electorate and in others is consistent across the state; that is, support for voluntary assisted dying in the community is very strong. In fact, in the Agricultural Region, 80.9 per cent of constituents support voluntary assisted dying, while 13.9 per cent of people are opposed to it.

The survey by Go Gentle Australia, which is the polling I have been referring to, asked a number of questions around the issue. Overall, it found that around the state there is 81.6 per cent support for it. I know that other members have referred to this, but it is important that we reflect on community sentiment on this issue.

When people in the Agricultural Region were asked whether a person with a terminal illness should be allowed to get a doctor to end their life, 83.1 per cent supported that statement and 81 per cent of people across WA supported that statement. Again, despite the changing demographics in my part of the world, there is strong support for voluntary assisted dying, and strong support for two independent doctors as a sufficient safeguard, with 72 per cent—that is, nearly three in four people who are saying yes. Again, the strength of the support for voluntary assisted dying right across the state, no matter where people live, is compelling.

I want to talk about some of the correspondence I have received. I will not read a great deal of that correspondence but I want to thank the individuals, not-for-profit groups and others who wrote or emailed or to whom I spoke around the electorate over the last couple of years while we have been talking about this issue, and especially in this last year. People have shared a lot of very personal experiences, as other members would be fully aware, and have also very strongly reflected their views on both sides of the spectrum. I have to say that, as other members have said, the strength of support for voluntary assisted dying has certainly been reflected in the conversations that I have had with people around the electorate. It has been reflected in conversations I have had with families and friends as well. I think that that obviously aligns with the polling that has been done too.

I just want to read a couple of short stories I have received. The first is from my old flying instructor who taught me to fly in the mid-2000s, Dick Welbon, and his lovely wife Dianna, from Esperance. It is a very brief but poignant email. Dick just says —

Colin,

I just want you to be aware that both Dianna and myself support the VAD bill as do many of our friends and my family. Although my parents pass away in relative peace Dianna's Father was a very different story. In his 80s his body deteriorated and over a long period of time he could do NOTHING ... He pleaded many times to be allowed to die You can imagine the effect on his wide family and the nursing staff as well I don't doubt.

We ask that you support this bill and persuade your colleges to do likewise.

Dick and his wife are lovely, very intelligent and considered people. They are not necessarily people who I personally would have thought may have had that view on voluntary assisted dying. Nonetheless, they have certainly reflected their overwhelming support for it and I think that certainly needs to be considered.

I also received, among other correspondence, correspondence from doctors in favour of assisted dying, in particular Doctors for Assisted Dying Choice. I refer to a couple of things that it said in its correspondence, which I am sure all members have received. I quote the letter —

There is far more support for VAD legislation amongst doctors than is commonly supposed. Even the 2016 AMA survey revealed that 51.5% of responding members were **in support of**, not against, assisted dying A survey by *Australian Doctor* in the same year found 65% of doctors were in favour of VAD.

...

Many throughout WA have been waiting patiently for end-of-life legislation. They do not like the idea of a 5% chance, at the end of life, of having a bad death. Doctors *will* make this Bill work if it passes. Contrary to what the AMA and some individuals have asserted, assisted dying is very much a part of medicine. It will represent an overdue and welcome option in the care of the dying.

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On careful analysis, we believe the Bill before the House is excellent. It is undoubtedly the safest of its type ever put before a legislature. It is the right Bill for WA and it deserves your support. It is compassionate and humanitarian, yet full of safeguards against abuse.

It is important to know that doctors genuinely support, and from all accounts the majority of doctors genuinely support, this legislation and think that this bill is good. It is absolutely important that we understand that.

One piece of correspondence that I received referred to the conscience vote. I think it is important for members particularly to reflect on what a conscience vote is. I said earlier in my contribution that I support voluntary assisted dying and I have done for some years, but in exercising a conscience vote, regardless of my view—mind you, it obviously reflects the views of my constituents—if the majority of my constituents did not want this, it would certainly be a much more difficult decision for me to support this legislation. I will not name the correspondent who wrote this letter, but they have said the following things that I think are important —

All three generations of our family support the proposed law on voluntary assisted dying. We are writing to ask you to vote in favour of that law.

They go on to talk a little bit about a conscience vote and what it means. I found their explanation, or definition if we want to call it that, very interesting. I will quote from this letter —

The term ‘conscience vote’ is a misleading one. The moral connotations of ‘conscience’ can lead to the false assumption that parliamentarians have a right to vote according to their own personal moral beliefs in defiance of what their electorates want. A better term is the one used in Canada—‘free vote’. A conscience vote simply means parliamentarians are free, for once, from voting as their party decides. It does not mean they are free from the responsibility of representing their electorate. Conscience is indeed involved in a conscience vote but what that conscience says is, “As an elected representative in a democracy, it would be wrong to vote against what a substantial majority of your electors have made it absolutely clear they want. To vote against the clearly expressed wishes of your electorate would be a betrayal of what democracy stands for.”

I think that that opinion, or definition if you like, from that correspondent about a conscience vote is very pertinent, because decisions like this weigh heavily on your conscience. Giving parliamentarians a conscience or free vote—whatever we want to call it—might sound in theory as though it makes things easy, but it actually makes it very difficult, because we have to think very carefully about what we are supporting and why, and also very much consider the views of our electorates and the people at large in Western Australia. This correspondent makes a very prudent point. As I said before, although I support voluntary assisted dying, I am still duty bound to reflect the wishes of my electorate, and that is certainly my intention with this bill.

I will go on to talk a little about some of my experiences with death and illness. Like many others who have spoken in this debate, I have not had a personal experience of someone close to me reaching their end of life in the awful way that so many people who have shared their stories have. I will talk about my grandfather, who was very healthy and pretty active right until the moment he passed away in 2012. He was one hundred and a half at the time he died. He was still driving out to the farm and “helping” until he was well into his 90s and he was fencing until he was in his late 90s. It was good to have him out there. It kept us busy anyway!

Hon Robin Scott: Supervising!

Hon COLIN de GRUSSA: “Supervising” is probably a good word, Hon Robin Scott! In 2012, sadly, he had a fall and broke his hip. At that stage, he was in a nursing home. He had surgery in Perth and they did a great job, but, unfortunately, as a result of the surgery, he had other complications, including kidney failure. He lay in hospital for a week with failing kidneys and he was not allowed to drink anything. He deteriorated pretty quickly and passed away during that week. I could say that that was a relatively gentle passage beyond this world. I know that our family was grateful that he did not have to suffer extensively during his passing, but I contrast that with a story that Jenny Rickerby has given me permission to read about her parents, Jim and Joy Jarratt. I will read this out because it is pretty important —

Jim and Joy, my parents

My Mum and Dad, Joy and Jim Jarratt, were fit, healthy people and active all their lives. They lived in Albany and were involved community members. They loved to fish. They’d go out and catch fish all the time, off the beach and the rocks. Mum had allergies and had a special diet. Catching her own fish was the only way she knew what she got was okay for her. They kept fishing until virtually they couldn’t, which was in the last year or six months of their lives.

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Mum got ill first, in 2012. She had breast cancer and had chemotherapy and radiation treatment in Perth. She came back to Albany and then they discovered the cancer had gone into her bones. She ended up going into hospice in Albany about January, 2013.

Albany Hospice is a wonderful institution and it does a fantastic job —

She spent about five weeks there before she passed away a couple of days after her 83rd birthday.

To start with Mum refused to take pain killers because she was allergic to morphine. She spent the first two weeks in agony. She'd get a burning sensation in her feet and it would work all the way up through her body and she felt like she was on fire and she'd be saying 'Oh no, oh no, oh no'. Eventually they convinced her to have painkillers with anti-nausea medication. It did make her a bit sick but at least she wasn't so much in pain. They were fantastic at the hospice.

...

Mum would have liked the option of assisted dying. She didn't want to go through the torment of what she was going through.

Dad died in February 2016, seven days before the anniversary of Mum's death. He had skin cancer and they'd been treating him for it. He'd lost most of his right ear. While looking for the cancer in his body they discovered an aneurism in his stomach. In July 2015 he had an operation in Perth for treating aneurisms that only a few people had even tried to have in Australia. It was successful but it created other medical problems. After the operation he got an infection and he said, 'I don't want to be here'.

He was having radiation treatment for the cancer at Sir Charles Gairdner Hospital in Perth and staying at Crawford Lodge. He didn't really want the treatment and they more or less insisted he keep on. He would walk over for treatment and there was no one at reception to see him. He would just go in, be treated and walk back to the lodge. Because they were treating his face, they burnt all the inside of his mouth and he wasn't able to eat or drink. They didn't stop until Dad collapsed in the waiting area and my sister went up and said 'What the hell's going on here?'. There was no one at the clinic keeping tabs on him—and Dad wouldn't say anything.

Dad ended up being admitted to SCGH. My other sister and I came up from Albany to see him and we didn't recognise him. He was skinny to start with and he'd lost even more weight in just a couple of weeks. They moved him to palliative care at Bethesda Hospital and he was there for two weeks.

He was able to eat a bit by this stage, but he'd decided he was going to die. He basically starved himself to death.

He was 85.

In 2009 my husband was in a motor bike accident in Thailand and had massive bleeding on his brain. They were keeping him alive, but there was no point. As a family we decided to turn off the life support. We knew that's what he would have wanted.

Jenny goes on to say —

Everyone should have dignity in dying. If a person is not functioning and they are just being kept alive for the sake of it, what's the point? I believe 'Do unto others as you would have others do unto you'.

That story from Jenny Rickerby is a contrast with the experience that my family had with my grandfather. It is important that we understand the very human nature of the suffering that people go through.

I want to talk a little bit about the human aspect and what goes through a person's mind when they are diagnosed with a potentially serious illness. I will talk about that from a very personal point of view. What is it like for those who are given a diagnosis of cancer or some other serious disease and what thoughts go through their mind and those of their family members? I can tell members from my experience that it is unlike anything else. The fear and uncertainty that surrounds you the moment your surgeon calls you in and says, "I've got some very bad news" is absolutely terrifying. That happened to me in March 2015 when I was told that I had stage 3 metastatic melanoma after having a mole removed from my left foot and a subsequent biopsy.

The small room that the surgeon had taken me into basically swallowed me up. Because I believed I was fine, I had gone up to Perth on my own and had left the family at home. Making those calls to your wife and your kids, who are pretty young, is incredibly difficult. Of course, while you are having those conversations and going through that experience, coming with all of that are the questions: What happens next? What are my options? What happens if I get to the point at which this is terminal? What happens if I have to go through rounds and rounds of chemotherapy and radiation, as so many other people have done, and we cannot beat this? As someone who had

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contemplated voluntary assisted dying as a tool for those suffering terminal illnesses, that obviously came into my thoughts. It was an option that I obviously did not want at that point in time, but I wanted to know that at the end of the day, if all else failed, I would have a choice.

Obviously we got that cancer very early. Subsequent PET scans, which I have regularly, have been clear since then, which is great. I was one of the lucky ones. However, I know that if I were ever in the situation of having a terminal illness, I would absolutely want access to the best care. Palliative care is a huge part of that care when someone reaches that stage, but voluntary assisted dying should also form part of that care package. That is the key part of voluntary assisted dying—it is a choice; it is voluntary. If a person were eligible, they could choose or not choose to seek access to it. They could go through the comprehensive process set out in the legislation and be given access to voluntary assisted dying and still choose to not use it. You are not forced to make that decision; you are given the choice to use it if you want to and are eligible.

I will talk a little more about palliative care and I will then go to another couple of stories. Before I do so, I want to acknowledge all those who work in the palliative care space. The work they do is incredibly difficult and challenging, but absolutely amazing. I think those people are absolutely wonderful. Palliative care is a tool that commenced in Australia in the early 1980s. Despite becoming more widely recognised, it is still something that is not well understood by most people. I think it is actually very important and very significant that we are talking a lot more about palliative care in the course of this debate. Palliative Care Australia defines palliative care as —

... person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.

In 2016, the WA Department of Health published “The End-of-Life Framework: A Statewide Model for the Provision of Comprehensive, Coordinated Care at End-of-Life in Western Australia”. This report estimated that the number of Australians who will die each year will almost double in the next 25 years, which will obviously place significant and increasing demand on the provision of end-of-life care. We are very lucky in Western Australia to have incredible palliative care services. In fact, Australia has one of the best palliative care systems in the world. A consistent argument against voluntary assisted dying is that there would be no need for it if only palliative care were properly resourced. I cannot accept that. No matter how good palliative care is, no matter how much it is funded—I obviously welcome any increase in funding or any additional funding for palliative care services—sometimes, for some people, palliative care is not enough. Palliative Care Australia, doctors surveyed by the Australian Medical Association, inquiries held here in Western Australia and in Victoria, and testimonies, including heartbreaking testimonies from experts, families, carers, coroners and first responders, testify to the extreme suffering some people experience as they die, despite the best efforts of palliative care. A 2018 report by Palliative Care Australia included an analysis of the palliative care experiences of over 22 000 patients nationally and found that two per cent of patients in the terminal phase suffered severe distress from pain. In addition, two per cent died in pain despite palliative care in that six-month period, and 569 people across Australia suffered severe distress from breathing difficulties during their terminal phase. Palliative care could not ease their suffering. In 2016, the Australian Medical Association asked its members to what extent they agreed with the statement “Palliative care and medical treatment cannot adequately alleviate the suffering of some patients.” Sixty-eight per cent agreed totally with this statement; 22 per cent disagreed. I would also like to quote the report from the 2017–18 parliamentary inquiry into palliative care in Western Australia, which states —

... too many Western Australians are experiencing profound suffering as they die. This is, in part, due to inequitable access to palliative care ... However, it is clear from the evidence that even with access to the best quality palliative care, not all suffering can be alleviated. Palliative care physicians themselves acknowledge this.

Our own parliamentary inquiry found that palliative care cannot ease everyone’s suffering. The argument that the solution to the trauma experienced when palliative care does not provide an adequate solution is to give more funding or more resources to palliative care actually does not make sense, because there will always be those people for whom palliative care cannot provide a solution. Palliative care and voluntary assisted dying are not mutually exclusive; they are both very important options for patients in the terminal phase.

I want to go on to talk a little about suicide, acknowledging Mental Health Week last week. We are all wearing our black dog pins today. This is a very serious issue across society. It is also a very serious issue in terms of patients who reach the end of their lives and are going through interminable suffering. I want to talk about the human experience of that. Unfortunately, very recently—in fact, during the most recent parliamentary recess—my cousin in the United Kingdom took his own life. He had a history of mental health issues, and I want to stress that his choice to end his life was as a result of mental health issues and not a terminal illness. What I want to talk about is the aftermath of the choice that he made, as difficult as it is. This was in the first week of the recess just gone. He was in his early 50s and had a couple of kids. His little sister, who I think would be in her early 30s, walked into the house and found him hanging from the ceiling. She had her kids with her—her little family—and it was

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very distressing for them. The immediate horror of that event for them and then the wider family was incredible, and it is still obviously very palpable across our family. The sad thing, of course, is that the horror of that event spread around the globe to relatives everywhere because of social media, before even his close family knew. I found it quite confronting that we found out about his death through the posts of people on Facebook, which in itself was quite distressing. That choice has had an effect on the family and friends around him. That effect is lingering in my family and will linger for some time. I knew this guy well; we were pretty close over the years. Is this what we want the families of those who are suffering from terminal illness to face—that the reality is that the only way out for some of these people is to tie a rope around their neck, asphyxiate themselves or use a firearm or whatever it is? I cannot accept that that is the choice we want to leave to those people and their families—I cannot accept that. The minister said in his second reading speech —

The coroner tells us that around 10 per cent of suicides in Western Australia are linked to chronic disease or terminal illness. These include deaths from plastic bag asphyxiation, hanging and gunshot. These are the wrongful deaths we should be concerned about. This is where our compassion is lacking. We can do better than condemn people to suicide.

I absolutely and completely agree with that. We must offer people at that time of life a choice other than a violent end. It may well be that simply offering that choice is enough for them to not do as my cousin did but actually go on with palliative care. They may never need voluntary assisted dying, but the knowledge that that choice is available may be enough.

I want to read a letter from Margo Beilby. This is another important one. It is about her husband who took his own life, but in a very different way. It is important to contrast the two—what happened to him and what happened to my cousin. The letter states —

Hon Colin De Grussa,

I am not one of your constituents as I now live in Roleystone but I am writing to ask you to please support the voluntary assisted dying Bill when it is presented to parliament later this year.

I see from your web site that your parliamentary office is in Geraldton. My husband, Michael Beilby, was deputy head at Bluff Point PS in the 70s. He was also a member of the Geraldton Yacht Club and editor of its newsletter. And a member of the St Georges Catamaran Club.

Mike was a lifelong asthmatic but he never let that slow him down. But gradually his condition worsened through chronic bronchitis to COPD (Chronic Obstructive Pulmonary Disorder). By 2013 he was down to 20% lung capacity. He also had been diagnosed with Parkinson's Disease. His doctors told him there was nothing they could do to cure either condition. He faced drowning in his own lung fluids. One of his doctors told him that if he were lucky he would get pneumonia and die relatively quickly.

He decided not to wait for that or a slow choking death. He joined Exit International and found that his best end of life would be Nembutal. He illegally ordered and paid for the drug online. It arrived on the 30th of July 2013. He wanted me to go shopping and come home and find him dead so I couldn't be charged over his death. I told him that after 51 years of marriage, I was not going to let him die on his own.

On the 31st he mixed the 10g of Nembutal powder in 150ml of water. Sitting in his favourite chair, looking out over our bush block in the house he helped to build, he drank the mixture and then a glass of port. He lay back in the chair and went to sleep and died. I sat beside him and held his hand till I was sure he was dead. Then I called his doctor who called the coroner.

...

I have read the submissions to the End of Life Choices committee and have been saddened by some stories of terrible deaths with people begging to be helped to die. I want everyone to have the option to have as good a death as my husband had.

I repeat: as good a death as my husband had.

The contrast between the violence of the only option now available to some people and what the government is proposing in this bill is incredibly relevant and incredibly important. It is certainly a compelling reason to support voluntary assisted dying.

As I said in my opening remarks, I am a supporter of voluntary assisted dying and have been for many years. I certainly support the right of a patient and their family to choose the treatment they receive. That should include a choice about how, and when, they die. The autonomy of a patient, and, indeed, the autonomy of any human being, is incredibly important, as is a person's need, and right, to dignity at the end of life. Suffering is a very human experience. It is a very individual experience. I do not know what it will feel like. I do not know what it will look

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like. But I know that if I were experiencing interminable suffering approaching death, I would want to choose how, and when, I pass from this life, and be given the opportunity to say my goodbyes to my family while I could.

I am supportive of this bill. I believe the bill has been very well informed through the lengthy process of the Joint Select Committee on End of Life Choices, the Ministerial Expert Panel on Voluntary Assisted Dying, and the experiences in other jurisdictions, both globally and in Australia through the Victorian legislation. I believe the bill provides a safe approach to legislating for voluntary assisted dying. It contains the necessary checks and balances. From a personal point of view, the bill is probably a bit more conservative than I would desire. I note the comprehensive process that a patient will need to go through in order to access the provisions of this bill. I say at this point that the government must do everything it can and leave no stone unturned to ensure that voluntary assisted dying is made available with reasonable equity to all people in Western Australia, no matter where they live. Other members have talked about this, and I am sure we will hear plenty more about it. I know this will be difficult, but it is absolutely critical. I hope that in the minister's reply he will give some assurance about how this will be done and what plans will be put in place in the second phase should the bill pass this Parliament. I hope this government will work constructively and diligently with the federal government to ensure that those who are eligible for voluntary assisted dying are given access no matter where they live.

There has been a bit of talk about potential amendments to this bill. I note that some amendments have been presented on supplementary notice paper 139, issue 1. I cannot stand before members and say unequivocally that I will not support any amendments to this bill, because that would be negligent on my part as a legislator. Each amendment must be considered on its merits. Most importantly, each amendment must be considered in the context of the whole bill, not as simply an amendment to an individual clause.

In the time I have left, I want to say a bit about one proposed amendment, having thought about this a bit in relation to my own experience. The proposed amendment provides that a health practitioner is not to initiate discussion about voluntary assisted dying. I believe it is incredibly important that a patient knows that their health practitioner will explain all the options that are available to them. When I was diagnosed with melanoma cancer, I went to see my GP to find out about the process and what was going to happen. I knew that I had to see a plastic surgeon and that he would cut a pretty big chunk out of my foot, right down to the bone, but I did not know much beyond that. At that stage, I had not been diagnosed with stage 3 melanoma. Stage 3 means that it has moved from the original site to somewhere else. I asked the doctor what I could do. I knew that the melanoma was pretty serious. She said that the mole that was removed was Clark level IV. I think the Breslow depth was 0.9 millimetres. Normally, that is outside the range at which a biopsy would be done. I asked her about what a biopsy would do, and she said I could have what is called a sentinel node biopsy, where they would find the first lymph node in my leg to which the fluid would move and check it out to see whether the cancer had moved. She said I could actually ask for that to be done. I did that, and they found that the cancer had moved to that lymph node, and that was why it was stage 3. If I had not asked for that biopsy and been aware that that option was available, I would have had stage 4 incurable melanoma, and I certainly would not be here today; I would probably still be in hospital, having significant treatment. The importance of good clinical practice and making the patient aware of every option available to them cannot be overstated. I cannot accept that it is good practice for a doctor not to give a patient all the options. Therefore, I am very concerned about that proposed amendment, having had that personal experience. It is important that we think about the bill in that context.

Having spoken about one of the proposed amendments to the bill, I actually do not believe the bill needs to be amended. I think the bill in its current form is excellent. It strikes a balance between safety and functionality, for want of a better term. Therefore, I do not believe the bill needs to be amended.

In concluding my remarks, it is my sincere belief that we can pass this legislation and introduce voluntary assisted dying in Western Australia. For all those who support this legislation, and for all those who will need this option at the end of their life, I hope we can do this for you. My wish is that this bill be passed expediently, notwithstanding the absolute necessity for rigorous scrutiny in Committee of the Whole House. I am sure we will do that. This house has a good reputation for making sure that we apply to legislation as much legislative scrutiny as we possibly can. I support the bill and commend it to the house.

HON ALISON XAMON (North Metropolitan) [12.07 pm]: I rise to make my contribution to the Voluntary Assisted Dying Bill 2019. Like others in this place, I acknowledge that this bill has generated a great deal of community sentiment. Like others, I have received hundreds, if not thousands, of emails, letters and phone calls. I have also, on more occasions than I am happy with, been cornered by individuals who wanted to discuss with me the provisions in this legislation and asked me urgently to vote either for or against this legislation. This is obviously a matter of deep public interest.

I also want to make some comments about how different the tone in dealing with this piece of legislation has been from the last time I debated this type of legislation back in 2010. Although much of the feedback that I have received has been strident, I note that despite everything I have received, I do not believe I have received one threat. That is

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very different from the tone of the debate that occurred nine years ago when I did receive some pretty nasty threats. We seem to have been able to progress further as a community in dealing with what is actually a very complex matter.

The Greens have a strong policy on voluntary assisted dying. The Voluntary Assisted Dying Bill 2019 largely reflects a lot of what is in our policy. As I said, the last time I spoke on this type of legislation—I am one of 14 members in this chamber who were elected at the time of the thirty-eighth Parliament—was in response to my colleague Hon Robin Chapple's bill, which sought to bring in a particular regime of voluntary assisted dying. I particularly want to acknowledge my colleague Robin who has been a champion of voluntary assisted dying for decades. He has worked very closely on this issue with community campaigners who understand that this is an issue that is very close to his heart. When I last spoke on that bill, it was not long after my grandfather had died. That had a big effect on how I responded to the bill at that time. My grandpa had been a long-term member of the Western Australian Voluntary Euthanasia Society, which was the previous incarnation of Dying with Dignity Western Australia. He personally begged me to support this legislation when it came on. At the time that he did that, my grandfather was dying of lung cancer. He was in his 90s. He had developed lung cancer from being a prisoner of war back in World War II. He was one of the Rats of Tobruk. Although he had kicked the nasty habit of smoking not long after he returned to Australia, unfortunately those years of being a POW meant that his lungs had been exposed to the risk of cancer. The final six weeks of his life, I would argue, were six weeks he really did not want to live anymore. If he had had his way, he would have cut his life short just by that period of time. He was, for his final days, in the Murdoch Community Hospice. I acknowledge that the staff there gave him first-class palliative care. We are very lucky to have some wonderful hospices within this state. Nevertheless, even with the very high level of pain relief that he was being proffered, it was not sufficient to manage his pain and, unfortunately, he died in a great deal of pain. One of the comments he made to me when he was in the hospice that has stuck with me—I referred to it back in 2010—was the sentiment that when he was young with his whole life ahead of him, he pointed out that the state did not hesitate to let him go off to war. But he made the point that now that he was old, had lived a full life and was dying, that the state would not let him die, and he felt angry about that.

As in 2010, I will be supporting this legislation, but I also have to acknowledge that since that time, much more has happened in my life and I am not dealing with the rawness of having lost a very precious and wonderful grandfather. That means that I will approach this legislation and indeed the debate around voluntary assisted dying not without my reservations. That is some of what I wish to talk about today. I want to start by saying, however, that I am very clear that I am able to distinguish between voluntary assisted dying when someone's life is ending and suicide. We know that modern medicine keeps people alive much longer than they otherwise would be alive. That can mean it has the effect of dragging out, particularly at the very end of life, someone's suffering when ordinarily their time would be up. The alleviation of enormous suffering when a person is about to die anyway, in my opinion, is demonstrably different from the tragedy of a life that is prematurely cut short by suicide. I am genuinely horrified at the coroner's assertion that about 10 per cent of people who take their lives now are doing so when they have reached end of life. I am particularly horrified because of the circumstances in which families come across the body of their loved one. We have heard from some people within this place already about the very violent and sudden ways in which people die and that they are dying alone. This also has the effect potentially of traumatising first responders who are left with the legacy of having to deal with the circumstances of that death. We also know that if it is a child in particular who discovers a body, that can have very serious implications in the form of post-traumatic stress disorder. I also know that there are far too many instances of people who are nearing the end of life anyway and attempt to take their life in order to cut short their suffering, but who are not able to complete that attempt and are sometimes left with terrible and debilitating disabilities as they reach the end of their life. Nobody can think that that is an okay situation; no right-thinking person would think that this is an acceptable outcome. I also note the genuine fear of those people who take their life, and indeed their family, that if the family is there when their loved one dies, they will be left to deal with the legal repercussions.

I note that a number of people in this place have already referred to the story of a particular advocate for VAD because she has been very vocal in this space for a very long time—that is, the story of Margo and Mike Beilby. I note that the speaker before me read out a letter from Margo. I want to make some comments about Margo's situation because Margo, or "Mabo" as she is known to me and my family, has actually been a very good friend of mine, a very close friend of mine, for over 20 years. Margo and Mike both used to volunteer in my office on a weekly basis. In fact, Margo still helps me out in the office—thank you, Margo, you are absolutely wonderful. I remember Mike slowly dying as he was working in our office. As has been mentioned, he was slowly drowning in his own bodily fluids and the coughing that we would hear from our office in the back room as he diligently did our filing and assisted with all sorts of things, would sometimes concern us quite deeply.

Mike was a curmudgeonly old man. He was very clear about his own mind and about what he would and would not do. I remember when he made the decision that he was going to seriously look at options and a safe way for him to end his suffering. What has been relayed during the course of this debate is that Margo and Mike actually

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tried to import particular drugs from China in order to achieve a safe death. The first lot of drugs were intervened; they never got them. It was the second lot of drugs that they managed to get hold of. Mike did everything that he was told he was supposed to do. He made the video to make it quite clear: "This is my choice. This is what I'm going to do. This is why I'm doing this. I'm dying anyway." They did everything that they were supposed to do to make it clear that this was very much Mike's choice. As Margo has relayed to everybody, when the time came and Mike made the decision that he was going to do this, she also made the decision that she was going to refuse to leave. She said, "You have been my husband for over 50 years, why would I leave you now when you are dying?" The simple answer to that came out of what followed. After he died, she rang the police and said her husband had died. The police turned up and they asked her where she had been. She said she had been there holding his hand. They told her, "You are not supposed to say that. You are supposed to tell us that you were at the shops or elsewhere." Being Margo, she said, "Why would I lie? I am not going to do that. I am going to be here. This is my husband." She was absolutely stoic. It did mean that my husband, who is also a lawyer, and I then spent the next 14 weeks assisting Margo, trying to make sure that she would not get charged, because she had not been responsible for Mike's death. He was very clear that he was going to make this decision, and good luck talking him out of it. She said to me, "Alison, I am prepared to go to jail if I have to. This is so important to me, I want to be able to make this statement." I am pleased that she did not end up getting charged, but I think this really highlights the fear that people have when their time has come and they are dying of the risk for the people they love if they decide they want to stay and be with them. I was very privileged to give the eulogy at Mike's funeral. As it turned out, Mike was actually a distant relative of mine, but we did not find that out until after we had known each other for about 15 years. That has always stuck very firmly in my mind.

I think there are a lot of reasons that people talk about wanting to have some sort of statutory regime around how they deal with the end of life, because it is about trying to avoid violent deaths, it is about trying to avoid unintended disability and it is also about the protection of the loved ones that they leave behind as well. I note that many people who are advocates for voluntary assisted dying are advocates not necessarily because they intend to avail themselves of this end-of-life choice, but because they want to know that the option is potentially there as no-one knows the circumstances of how they are ultimately going to die. I am really pleased that there has been so much discussion about the choice of palliative care. I am really pleased to see the recent successive announcements that have talked about a boost to palliative care. I think it is important that we acknowledge the Parliamentary Friends of Palliative Care who have been tireless in raising the issue of the need for palliative care options and how inadequate they are in this state. The work of that group is not yet done, because even with all the announcements we have had, we still do not have enough palliative care options available in this state. It is beholden on all of us to ensure that if this legislation is to pass we make sure that it does not become a default option simply because people are not able to receive the care that they want and need at their end of life. To those people who have approached me and told me not to talk about palliative care because it is a distractor and just to talk about voluntary assisted dying I say, "No, you are wrong." As far as I am concerned, the two are intrinsically linked, and I think it is absolutely essential that we keep talking about palliative care, because we also know that people sometimes call for voluntary assisted dying because they have not been getting the services that they need. I welcome the fact that we are undertaking to significantly boost palliative care in this space. We will have to keep going though, members. We will have to make sure that we do not lose the promises that have been made and that this area continues to expand. I believe that most people are likely to choose the option of palliative care. I do not have anything to base that on; it is just an opinion. I think palliative care can be superb.

I have spoken in this place before about the death of one of my best friends two and a half years ago from cancer. He never expressed a desire to take his life. I was there the weekend that he died and, frankly, he had a superb death. He had a wonderful death. He died at home with his wife, his children and obviously us, his best friends. The palliative care that was offered by Silver Chain was superb; it was so good. I think it is true that when palliative care is offered, a lot of the time it is sufficient. That is why it is all the more important that we make sure we do not drop the ball on this and that palliative care services are always funded. I remain concerned to ensure that this option is available for anyone who wants it, regardless of where they live. I think in a very large state it is very hard sometimes to deliver the appropriate services, and that is a challenge we need to meet. I make it clear that I do not think we are anywhere near close to being able to be comfortable with where we have landed, but I accept also that for a small number of people, my grandpa included, palliative care can reach its limitations. I have heard it estimated that palliative care cannot quite deal with the extreme pain of between two per cent to four per cent of people. I hope they are the only people we are talking about here when we talk about voluntary assisted dying.

I also note that in some ways we are here talking about formalising what we know quite a lot of doctors are actually undertaking in practice. I think we need to acknowledge that. I know of one family matter. I am not going to go into detail, because I am not interested in getting anyone into trouble. I know of people who have means sometimes using those opportunities to give people that alleviation from suffering at end of life that they so very much crave. We should not try to pretend that that is not happening already. We should not try to put this out there as though

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it is something utterly new that has never happened. Some doctors have been coming out and admitting this. I express some disquiet at the enthusiastic fervour that some doctors seem to demonstrate towards the opportunity to kill their patients, but that aside, I think it is important to acknowledge that many compassionate and professional doctors are quietly doing this in conjunction with patients and family all the time.

I also note that many have chosen to portray this debate as simply being between people of faith and secular interests, and I do not for one second accept that that is the case. It is true that many people of faith have concerns. We have all received correspondence from a number of churches of different faiths urging us to oppose this legislation. I have also heard from many individual people of faith who have urged us to reject this legislation. I have heard the view that VAD must be rejected because to suffer is to be closer to God and those with those views are hoping that I am a god-fearing woman. Members, to be honest, I am not a god-fearing woman. I am more of a New Testament kind of gal, and my God is the ultimate loving God and is not really interested in revenge. In any event, I also recognise that those people with this faith approach are not necessarily in the majority. But many Christians and people of faith who I have heard from have expressed their distress about the possibility that people who do not really want to die will end up having their lives cut short. I think that it is irresponsible for us to simply dismiss those concerns on the basis that they are driven by faith, rather than taking them seriously. I think those concerns are very valid and we must listen. I must also note that I have heard from many Christians and people of other faiths who support this legislation. Indeed, there is a diversity of faithful Christian understandings of, and responses to, dying and voluntary assisted dying that are consistent with the affirmation that life is a gift of God, regardless of the circumstance. Many of those Christians believe they have been called to be a loving and supportive community around people in need of care as they or their loved ones move closer to the end of mortal life, and as citizens in a pluralistic culture, they also seek to care for and respect their neighbours who may not hold on to their faith in God, yet may experience fear, uncertainty, pain, grief or sometimes extreme and extended suffering as they prepare for their own death or that of their loved ones. They therefore recognise that exploring, accessing and making provision for, or conscientiously objecting to, voluntary assisted dying are all possible Christian responses. It is important to note the diversity of approach from people of faith about this as well, so I do not accept the characterisation of this debate as one of people of faith versus others.

Even though I support this legislation, I want to make a number of comments to those people who have urged me to support it, many of whom, in my opinion, have taken a rather unquestioning approach to their support of voluntary assisted dying. Even though I am voting for it, I do not necessarily agree with all the sentiments that have been put to me. I want to start with my concerns about the title of the report of the Joint Select Committee on End of Life Choices: “My Life, My Choice”. I want to say how sad and disappointed I was when I first saw that title. I recognise that that principle—the idea that it is my life, so it is my choice—is a view that has been widely espoused, and that is undoubtedly why it has been reflected in the title of the majority report of the Joint Select Committee on End of Life Choices. As a suicide prevention advocate, and as a child bereaved by suicide, I want to say what a distressing phrase that is for me. None of us are islands. When someone takes their life, it has a ripple effect, and I do not accept that our lives belong simply to ourselves. I am the mother of three children, and I am a wife, and I believe that when I chose to bring my children into the world, and when I opted to become a life partner to my husband, I was deciding to intertwine my life with theirs. If I were to take a decision to prematurely take my life, that would have a lifelong effect on them. My father chose to take his life when my brother and I were just children. Apparently, advocates of “my life, my choice” would say that it was his life, and it was his choice, to which I say, “Where was my choice? Where was my brother’s choice?”

As I have said already, I accept that this bill is not about suicide—the premature cutting short of the promise of life—but, instead, about the alleviation of terrible suffering at the very end of life, when death is inevitable. I do not accept, and I never will, the idea that just because it is your life, it is your choice, because, as humans, we are complex creatures with interrelated relationships, and I am not persuaded by arguments from people who say that if they want to die, the state has an obligation to facilitate that just because it is their choice. I also think that that sort of approach takes away from the hard work that we put into suicide prevention efforts—the millions of dollars that we invest at both a state and federal level, and the amount of human energy that goes into campaigns to try to make sure that people do not take their own lives. We know that trying to prevent suicide is trying to address issues of despair and hopelessness and, for many, mental illness.

On that note, I have also heard a couple of people advocating for the capacity to access voluntary assisted dying in cases of severe and chronic mental illness. It is not in this bill—thank goodness. Until the day I die, I will never agree to that. I believe that people with mental illness, no matter how severe, are able to engage in recovery such that they can have good and meaningful lives. To anyone who wants to write to me, giving me their stories about how their adult child has a terrible mental illness and how much better off they would be if they were not to live anymore, I am sorry; I am not your person. Go and find someone else to advocate for you because it will not be

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me. This debate needs to focus on the continuum of final healthcare options when someone is effectively facing entire bodily collapse and is about to die.

I have also heard quite a few people voice the sentiment that they cannot understand why there should be barriers to accessing VAD at all. I am very clear that if someone is asking the state to help them die, there must be barriers so that we can ensure that people are not coerced into taking their own lives. Threat or coercion is actually a thing. I was the Deputy Chair of the Select Committee into Elder Abuse and, as has been already articulated by other members in this place, the issue of psychological abuse is a genuine thing; it is a huge thing. That, coupled with financial abuse and the idea of inheritance impatience, was seen, in evidence taken by the committee, to be a genuine and real risk for elderly people. There is also the idea that people do not want to feel as though they are a burden, and really internalise that idea of being a burden. These are very genuine and real concerns. I do not want to see this bill become a vehicle by which we entrench ageist views towards people. Like other members, I have received multiple emails from children of elderly people saying that they want to have voluntary assisted dying because they say that their parents would not want this. That may be the case, but we do not know. I am always a bit shocked by the number of people who advocate for that. It is interesting, because people whom others may view as having poor quality of life may actually want to keep living. It should never be the case that people are able to be coerced into making these sorts of decisions. This will be really critical. If this legislation is to proceed, we need to make sure that training will be available for doctors to enable them to identify coercion when it occurs. We already know that we need to have training around elder abuse. There is already some training, but we need to have more training about how to identify risks of family and domestic violence, and training on risks around coercion at the end of life will have to be one of those things we are advocating for doctors as well.

I note that people with disability have also expressed great concern about this legislation, and I hear those concerns. I think it would be a mistake for people to simply dismiss those concerns. I want members to think about how offensive to people with disability some of the language that we use around this debate can be. We talk about, for example, a loss of dignity if people require assistance with toileting, or a range of intimate functions, and how preferable death would be to ever having to have someone assist with toileting. I am going to make it clear that many people with disability require assistance for their whole lives with personal, intimate hygiene, and I want to ask whether we are suggesting that those disabled people are devoid of dignity. Is that what we are suggesting? Or worse, are we suggesting that they would be better off dead? I certainly hope not. Good friends of mine have expressed their frustrations about the way in which some people have used this language in this debate. Their lives have inherent dignity. Whether because of illness, childbirth, injury, disability or terminal illness, we may need help, but that does not make us inherently devoid of dignity. Likewise, we talk about wanting to end life because of pain. Many disabilities bring a lifetime of pain, but that does not mean that people who live with permanent or chronic pain wish to die, so let us be careful about how we use that language. The language of suffering is also highly subjective. One may lose all physical ability but that does not mean that one cannot live a joyous life.

Probably the most dangerous language we use for people with disability is that of burden. Advocates of voluntary assisted dying often say that they want to ensure that they do not become a burden for others, and that is often a critical point in their reasons for wanting the state to assist them to end their life. That is the slippery slope that people with disability fear. Far too often, people with disability are made to feel that they are a burden. We see a systemic denial of critical medical care when individual doctors make a determination, consciously or not, that someone's life perhaps does not warrant saving. This has emerged in multiple coronial inquiries, as well as in the lived experience of people with disability and the families of people with disability. People with disability are particularly concerned about the language of burden. Language matters, but for those advocating for voluntary assisted dying, I point out that the safeguards matter as well.

To those who say that the legislation is too stringent, I say that if someone is going to ask the state to help them to die, it is absolutely incumbent upon us to ensure that those who do not want to die, do not die, and that those who are pleading for their lives to be recognised as having inherent value are heard. The same concern can be extended to Aboriginal Western Australians, who have also expressed concerns about the message it may send about the value of their lives. We put a lot of effort into trying to save the lives of Aboriginal people, whether because of poor health outcomes or the disproportionate number of First Nation people who take their own life. We need to listen when Aboriginal people say that they are confused about what message this will send. We need to make sure that our health services continue to be trusted; that needs to be at the forefront of our consideration. We also need culturally appropriate training and professional development, co-produced by Aboriginal Australians and delivered by Aboriginal Australians. I hope the government recognises that it needs to do that.

I remain concerned about the issues for regional Western Australians. We will talk more during Committee of the Whole House about ensuring that regional Western Australians are able to access appropriate palliative care—which I have already spoken about—and appropriate advice, services and specialists. There is clearly a gap that

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will have to be looked at, and that challenge will have to be met. As I have already said, I do not understate how much of a challenge that is; it has always been a challenge to try to deliver appropriate and adequate services within a state as large and remote as Western Australia.

I note some of the concerns that have been raised about doctors—that there may be a tendency with some doctors to flag themselves as being the people to go to if people want to ensure quick access to voluntary assisted dying. These sorts of things happen. I recall when my children were little that there were a number of doctors who put themselves out there as being the people to go to if someone wanted to get a conscientious objection form for vaccination; they were the go-to people. We know that these things occur within the medical profession, so we will have to be careful that when decisions are made to end life—because there is no turning back from that—they are made in the most sober and thoughtful way that medical professionals can make possible.

I also flag the concerns that have been raised with me by mental health professionals. They are particularly concerned about the lack of rigour in the assessment of someone requesting an end-of-life option because they have developed a mental illness, are deeply distressed and are experiencing a mental crisis. We should not ignore that; I think that is a genuine concern. As I have already said, I would never support voluntary assisted dying for someone who wants to die because they have a mental illness, although I recognise that if someone is depressed because they are dying, it does not necessarily mean they are not fully able to make a conscious decision about end of life. It is important that we get that balance right and ensure that people are not requesting to die for the wrong reasons.

I have also been approached by people who have said that it would be out of line for me to move amendments to the legislation, that I simply have to support the bill in its current form, and that it would be outrageous for me to even contemplate anything else. My response to that is that they are wrong. As members know, I propose amendments to a lot of bills in this place. Why I would suddenly renege on my responsibility to scrutinise legislation with one of the most important bills that this Parliament has ever debated, defies logic. I will not be taking that approach. Although I have listened to people who are both vehemently for and vehemently against the legislation, I have also listened to people who are quietly supportive of the overall principle but have nevertheless expressed significant disquiet about unforeseen implications. Therefore, I think it is very important that I listen attentively to those concerns.

This is not a black-and-white issue, and this bill was never going to be a take-it-or-leave-it matter. It is my role to be party to the crafting of legislation that the chamber should endeavour to make as safe as it possibly can be. There will obviously be debate about what that will look like or, indeed, whether we can ever achieve a point of ultimate safety. I am frankly offended by the suggestion that I should not even consider proposing amendments, let alone vote for amendments, even if I am strongly of the view that they are necessary improvements, because of course I will.

As I made clear at the beginning of my contribution, I will be supporting the second reading of this legislation and, most likely, the third reading, unless someone moves an amendment to include voluntary assisted dying for people who want to die because they have mental illness, in which case I will be out. But I will also carefully contemplate every amendment and vote with my conscience, as is my right. I understand that this legislation will dramatically transform our legal and health landscape. It challenges us as a community and it is a significant shift in the way in which we view and approach life and death. Anything less than the most thoughtful and considered scrutiny of this legislation would constitute a major disservice to the Western Australian community. With those thoughts, I look forward to the committee stage, when we can go into detail a lot more. I commend the bill to the house.

HON AARON STONEHOUSE (South Metropolitan) [12.49 pm]: I rise to speak on the Voluntary Assisted Dying Bill 2019. As a part of classical liberal values, the Liberal Democrats believe that there is no more fundamental expression of individual freedom than the right to decide what you do with your own body. The Liberal Democrats demonstrated this commitment when my colleague, then Senator David Leyonhjelm, introduced a private senator's bill—the Restoring Territory Rights (Assisted Suicide Legislation) Bill 2015. That bill would have removed the prohibition on the Northern Territory and the Australian Capital Territory to legalise assisted suicide. However, it was narrowly defeated at the second reading in August 2018.

Although I am equally as committed to ensure individual freedom is preserved and upheld, I am a very different man from my former colleague. As a Christian and as someone with rather conservative sensibilities, I approach this legislation from a very different perspective than many of my party. I could share personal stories of my experience of the loss of loved ones, but I would rather not in this case, not only because I feel they are private, but because I would rather not look at this legislation through the lens of my personal experience. When dealing with moral and ethical questions like this, it is important to suspend personal desires and feelings and instead consider this legislation cognisant of the fact that the decisions that will be made here will have a profound impact on the rest of society. Legislators have an immense responsibility, regardless of their support for or opposition to voluntary assisted dying as a concept. We have a duty to critically scrutinise the provisions of this bill and to

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leave no stone unturned. However, we must also consider that there are fundamental questions that go beyond a clause-by-clause analysis of the bill—questions of autonomy and of the intrinsic value of human life that transcend our examination of the law.

It is for these reasons that I will not be quoting polling data today; I do not think it is terribly relevant to what we are doing here in the Legislative Council. Members of a representative democracy are entrusted by their constituency to research and consider legislation carefully, and not to be blindly led by the whim of popular opinion. Members of Parliament have a responsibility to carefully consider the fine detail and the minutia of legislation. As a result, I have consulted widely in the lead-up to this debate. I met with people from both camps and those from neither. I have had very constructive and informative meetings with Hon Malcolm McCusker, QC, who chaired the Ministerial Expert Panel on Voluntary Assisted Dying and who has long been and remains someone for whom I have the utmost respect. I met with representatives of Go Gentle Australia, including Andrew Denton and his team. I had the opportunity to meet Belinda Teh. I have also corresponded with church representatives, including Archbishop Peter Carnley, whom many would list among our leading theologians. I have had the opportunity to meet with the Australian Christian Lobby and Peter Abetz. I have met with palliative care experts, including Dr Anil Tandon, who chairs the WA Palliative Medicine Specialist Group, and Dr Alison White, the director of hospice and palliative care services at St John of God Murdoch's Community Hospice. From further afield, I have met with Dr David Grube, who chairs the ethics committee at Lumina Hospice in Oregon, who was able to offer me some insight on how assisted dying has been and is being handled there. I also had the opportunity to meet with Professor Kissane and a representative from Hope, Dr John Daffy. I also hosted David Seymour, MP, the architect of New Zealand's assisted dying laws, at a Q&A session here at Parliament House, which I was pleased to see several members, along with some from the other place, attend. I am also grateful to the office of the Minister for Health and various staff from WA Health who made themselves available on a number of occasions to brief me and my staff.

Like all members here I suspect, I received considerable feedback within my electorate, the South Metropolitan Region, much of which has proved insightful. The conversations I have had have been detailed and, quite often, brutal. I have come away from them with a far greater understanding of the palliative care industry and voluntary assisted dying than I had to begin with.

When considering the issue of voluntary assisted dying, it is important for legislators to ask ourselves the following question: do we have the right to control what someone else does with their own body? We may have the political authority to do so, but do we have the right to do so; and, is it right to do so? This is fundamentally a question of autonomy and I believe it is at the heart of this issue. Why do I pose this question and not the opposite, for instance: does someone have a right over their own body? To understand that, we must understand the liberal tradition of a presumption in favour of liberty. Seventeenth century political philosopher John Locke described man as being naturally in a state of perfect freedom to order their actions as they think fit, without asking leave, or depending upon the will of any other man. It is a view that nineteenth century philosopher John Stuart Mill echoed. Mill said the burden of proof is supposed to be with those who are against liberty, who contend for any restriction or prohibition; the *a priori* presumption is in favour of freedom.

The presumption of liberty is a fundamental liberal principle. It holds that the onus of justification is on those who use coercion to limit freedom. It is a principle that is expressed in social contract theory, in which political and legal authority must be justified. If we accept that there is a presumption in favour of liberty, then we must ask ourselves: when is it justifiable to use coercion to control the actions of another? This again is a question considered by Mill, who developed what we now know as the "harm" principle. Mill said —

That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise or even right ... The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. The part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

The phrase "your freedom to swing your fist ends where my nose begins" captures the general sentiment of that principle. Of course, Mill understood that such a principle could apply only to those who are able to exercise their freedom responsibly. Paternalism, under Mill's harm principle, is still justifiable for those incapable of exercising personal responsibility for their actions, such as children or those with severe cognitive impairment. It is Mill's harm principle that I apply when considering the issue of voluntary assisted dying. It may sound like a rather atomistic view of society; it is actually not. Indeed, no man is an island and I am an ardent supporter of the institutions of civil society—family, marriage, church, community groups and voluntary organisations. We do have a responsibility to one another, but the questions at the heart of this legislation are: When is it appropriate to use coercion to prevent someone from exercising their own free will? Do we have the right to use coercion to deprive someone of their

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freedom because we disapprove of their choices? Do we have the right to impose one system of values upon the rest of society? I remind members that the right to do something is apart from the exercise of that right. It might surprise some members to learn that I do not personally approve of voluntary assisted dying. As a Christian, I hold certain views about suicide and about the sanctity of life. In fact, if someone I knew expressed a desire to access voluntary assisted dying, I would try to dissuade them and convince them otherwise. I might argue or debate with them. I might want to show them the error of their ways through outreach, volunteerism and showing them alternative paths. However, despite my disapproval of their actions, I do not feel it is sufficient to use coercive power to prevent them from exercising that right to do so. If we disapprove of someone's choices, we do not necessarily need to resort to government interference to stifle their freedom.

However, my support for this legislation is not a foregone conclusion. At the heart of liberty is the absence of coercion by others. Consequently, the liberal state's commitment to protecting liberty is essentially the job of ensuring that its citizens do not coerce each other without compelling justification. If you apply this to voluntary assisted dying, then it is very clear that the state has a role in voluntary assisted dying to prevent the coercion of others. As I say, my support for this bill is not a foregone conclusion. As I indicated in the lead-up to the debate, I support the right to access voluntary assisted dying. Members might say that I support voluntary assisted dying in principle. But I am concerned about how the regime will operate. A policy and a bill are two very different things.

On Tuesday night, Hon Nick Goiran asked members the question: is it possible to design and implement a safe euthanasia regime? Notwithstanding, the confusion of terms in that question and that what we are discussing is voluntary assisted dying and not euthanasia, it is an important question to ask. I have spent my contribution talking about the principles of liberalism.

Sitting suspended from 1.00 to 2.00 pm

Hon AARON STONEHOUSE: Before we broke for lunch, I was summarising the classical liberal view of autonomy and personal freedom, and my support for the idea that individuals should be free to make choices about their own body, so long as they are not harming anyone else. However, I made it clear that my support for this bill is not a foregone conclusion. My support for this legislation will be contingent upon there being adequate safeguards in place to ensure that there is no coercion and to ensure that those who access voluntary assisted dying are doing so fully informed and with the capacity to make decisions about what they do, and on a number of other areas that I will outline in just a moment. It is my intention at this time to vote for the second reading of this bill, not in support of the bill as of yet, but to at least allow us to proceed to the Committee of the Whole House stage so that the bill can undergo a thorough examination, clause by clause, and so that members will have an opportunity to examine how the bill will function and explore the possibility of amendments. I am unable to say at this time whether I will vote for the bill at the third reading, as the bill we are dealing with right now and the bill we have at the third reading may be very different beasts. If the bill is amended or certain information is illuminated through the Committee of the Whole House stage, members will have to consider the quality of the bill at the third reading as it stands. I cannot say at this point whether I will vote for the third reading. However, I certainly hope that my concerns can be addressed and I hope that through the Committee of the Whole House stage we can find and ensure that there are safeguards in place.

I take a moment now to outline some of my concerns with the bill as it currently stands. I will start off with one that has already been raised by previous speakers, and that is the lack of a prohibition on medical practitioners raising the question of voluntary assisted dying with their patients. In a perfect liberal society, there should be no problem with a doctor raising such a question with their patients. However, we have to acknowledge that there are people out there with cognitive impairment or with mental health issues, and there are some folks who, in the absence of cognitive impairment or mental health issues, may merely be susceptible to suggestion and gaslighting, and easily led. Cultural differences may have also been overlooked. In our western liberal democracy, there is an emphasis on the autonomy of the individual. There is, I think, a healthy scepticism of authority, and I may be wary of the recommendations of my doctor and not follow their advice blindly. That is not necessarily the case in all cultures. The position of authority that a doctor holds may be held in higher esteem in different cultures. There are also issues of language barriers, whereby patients who may not have the best grasp of the English language are dealing with doctors who might be unfamiliar with their patient's difficulties in communicating.

I think that the issue of doctors or medical practitioners raising the question of voluntary assisted dying with their patients is compounded further when we consider that, under this regime, doctors will be able to administer the poison to carry out voluntary assisted dying. The doctors—in this case, it would have to be three separate medical practitioners—would become, amongst the three of them, the judge, jury and executioner, if I can use a blunt analogy. There is, in my mind, a fear of more activist doctors taking a very active and progressive, perhaps even pushy, role in facilitating voluntary assisted dying. That they are able to raise the question of voluntary assisted dying, assess someone's capacity and then refer on to a colleague who can administer voluntary assisted dying raises some concerns that the safeguards in this bill will not be adequate to prevent wrongful deaths in some circumstances. In my consultation, I met with doctors who are intimately familiar with the regime in Oregon, which is the basis for

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the Victorian regime, which is the basis for the Western Australian regime. It was explained to me that in Oregon, doctors do not administer voluntary assisted dying; voluntary assisted dying is self-administered. There may be concerns about someone with a medical condition who is unable to move their arms because of some motor disorder. In those instances, they are able to use a straw. There may be an issue with someone who is unable to swallow due to throat cancer. In those cases, they are able to use a stomach pump. There are ways around it. It seems to me that if it is to be administered by a physician, by a medical practitioner, that should be the exception, not the rule. I will be very keen to see under what circumstances a medical practitioner can administer voluntary assisted dying. It is important, because we are discussing voluntary assisted dying and it is not intended to be a euthanasia regime or one in which a doctor puts a patient out of their misery. It is meant to be a self-administered voluntary assisted dying regime, in which people exercise their own free will, are able to make fully informed decisions as rational adults, make this decision and do it to themselves.

I also have concerns around the assessment of capacity. This is important for me, because my support for the rights of an individual to make their own choices is based on the idea that they are exercising their own free will and that they are autonomous agents. Therefore, we need to be absolutely certain that those people who access voluntary assisted dying are capable of making those choices, are fully informed and are free from severe mental illness or cognitive impairment when they make those decisions. I have some concerns about whether a general practitioner is best placed to make that assessment. I understand there will be an online training course for GPs; however, it will be a six-hour online course, of which an hour, perhaps, will be dedicated to the assessment of capacity. I have serious doubts that that is adequate in training someone otherwise not familiar with capacity assessment in how to carry out that function. It has been put by advocates of the bill that a GP is best placed to assess capacity. They are someone's family doctor, they are someone who has a close relationship with a patient, someone who meets with them on a regular basis and probably has a good idea of their family and home situation. That may be the case for some people, but many others, who perhaps can afford to see only GPs who bulk bill, go to a medical clinic at which there are several doctors and see whichever doctor can see them first. That has certainly been my experience. Being young and relatively healthy, I do not have a regular GP; I go to whichever clinic or whichever GP will see me first in the time that I can fit into my busy schedule. I believe that is the case for many people. Those GPs would have no idea what stresses or outside influences there might be on my decision-making capacity at that time.

There is no requirement for a psychiatric assessment. This is a concern to many in the field of psychiatry. However, it is unclear to me at this time how that might be addressed. Mandatory psychiatric assessment would be very onerous and difficult for people in regional WA to access. However, I am very keen to explore that issue. It has been suggested to me that a presumption against capacity rather than a presumption of capacity might be one way to address that. It is unclear to me at this time whether that might be a suitable way forward. It is something I will examine in the Committee of the Whole House. There is no mandatory notification of family members by a coordinating medical practitioner. However, it is a little unclear whether such notification would be ethical. It might certainly be the decent thing to do, but given the privacy and confidentiality between a doctor and their patient, mandatory notification would be unethical. That is something I am looking to explore as well.

I have concerns about a few other areas of this legislation but perhaps the one that leaves me most unsettled at this time is the lack of respect for the exercise of conscience. If voluntary assisted dying is an expression of free will and is an exercise of a patient's free will and their conscience to end their life if they so choose, surely it is right that conscientious objectors be afforded that same freedom: that medical practitioners who are conscientious objectors should be free from an obligation to be part of a regime that they find counter to their own moral values. We cannot grant freedom to one group of people, those suffering a terminal illness who wish to end their lives, at the expense of the freedom of another group of people—that is, medical practitioners with a strong moral objection to voluntary assisted dying. There are those who will disagree with that statement and say that there is an obligation on doctors to provide information to their patients about all the medical options available to them. I disagree with that. In that is an assumption that voluntary assisted dying is a medical treatment. I do not think it is. It is an alternative to medical treatment. I still think people have the right to do it if they want to, but it is not medical treatment.

There is also an assumption that with a right or a freedom comes an obligation. I think it is a misunderstanding of what freedom really is. Freedom is an absence of coercion. That is not a positive right that government must bestow onto citizens. It is something that government cannot take away from you. Twentieth century political theorist and philosopher Sir Isaiah Berlin summed this up quite clearly, when he said —

I am normally said to be free to the degree to which no man or body of men interferes with my activity. Political liberty in this sense is simply the area within which a man can act unobstructed by others. If I am prevented by others from doing what I could otherwise do, I am to that degree unfree; and if this area is contracted by other men beyond a certain minimum, I can be described as being coerced, or, it may be, enslaved. Coercion is not, however, a term that covers every form of inability. If I say that I am unable to jump more than ten feet in the air, or cannot read because I am blind ... it would be eccentric to say that

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I am to that degree enslaved or coerced. Coercion implies the deliberate interference of other human beings within the area in which I could otherwise act. You lack political liberty or freedom only if you are prevented from attaining a goal by human beings.

It is interesting that in this discussion around voluntary assisted dying, such an importance is placed on preventing coercion—coercion of a vulnerable person being steered towards voluntary assisted dying against their will. There is little discussion about the coercion of medical practitioners by placing upon them an obligation to carry material and pamphlets or an information pack in their office and hand it over on request to a patient. There is clearly a need for those suffering to access information about voluntary assisted dying. However, I do not think we need to do that if we are putting an obligation on medical practitioners. In fact, it seems inconsistent. If there is a desire that medical practitioners provide their patients with every available medical option, why does the bill not include an obligation to inform patients about the availability of palliative care as part of their consultation with someone seeking voluntary assisted dying? No such obligation is in this legislation. It does not exist in any other statute that I am aware of. Clearly, medical practitioners do not currently have a statutory obligation to provide every option to their patients. To do so, I think, would be rather difficult. That is perhaps a debate for another day. It has been put to me that upcoming doctors and medical practitioners will know that there is an obligation going forward; therefore, they will not get into medical practice if they are conscientious objectors. That is ridiculous. It is absurd to exclude from medical practice an entire group of people because they have strong moral beliefs and do not want to be part of this regime.

I have always used my vote in Parliament to protect and uphold personal freedom and personal choice and I will do so again to protect the freedom of medical practitioners to be conscience objectors. As I said before, my support for this bill is not a foregone conclusion. We cannot sacrifice the freedom of some people to enhance the freedom of others. Freedom should be mutually beneficial to all. At this stage, I give my in-principle support to voluntary assisted dying. I will vote for the second reading and follow closely the Committee of the Whole House process and will wait to see what bill we have at the end of that process and reassess the legislation at the time of the third reading.

HON KEN BASTON (Mining and Pastoral) [2.17 pm]: This is a very difficult subject to grapple with, even though it is a scenario that nearly all of us will face at some point or with someone very close to us. When considering my position on this legislation, I have endeavoured to be informed by experts in the field of health care, particularly palliative care, and by the numerous constituents who have contacted my office and, I am sure, many others, in an effort to have their feelings on this very contentious subject heard and considered. I will have it noted that approximately 63 per cent of correspondence into my office was against or at least very concerned about the wider effects of voluntary assisted dying, while 37 per cent was in favour of it. For those who do not know, my electorate office is based in Broome.

Many of the speeches made about the Voluntary Assisted Dying Bill 2019 have been compelling and enlightening and demonstrate a great effort to deal with the incredible complexities surrounding the application of this legislation; that is, people will be able to decide to take their own lives through a process administered by the state.

As a representative of the Mining and Pastoral Region, I am genuinely concerned about how this legislation will impact on the lives of people living in the region. The Mining and Pastoral Region hosts some of the most isolated and underserved communities in the nation. There are towns and communities that struggle to retain basic services, and they face financial, geographical and often cultural barriers in accessing adequate health care. Interestingly, a few years ago when I visited Rudall River National Park, the nurse at Punmu told me they had been waiting for over two years to get a dentist out to the community. Of course, dentistry was not covered under the patient assisted travel scheme, so they could not take the patient to a larger town.

I am very concerned that this legislation will pass while people living in the Mining and Pastoral Region are left without genuine choices about end-of-life care. I am still extremely sympathetic to the plight of people facing terminal illnesses and completely understand the desire to want control over that process. I have certainly grappled with the tension between my belief that an individual should ultimately have control over their life and my concern about the effect this legislation could have on our society as a whole. This makes it very difficult for me to consider voting for this legislation. However, during the time I have spent considering this issue my concerns and uneasiness have increased. I fear that if voluntary assisted dying is accepted as the ultimate form of pain relief and the way to end suffering, our values concerning life and the desire to protect and prolong life will shift.

There is also the wedge effect to consider. Many of us may feel comfortable with the legislation before us and its apparent safeguards, but are we utterly confident that a future government will not seek to significantly expand the boundaries of this legislation? Are we comfortable opening the door to that possibility? I, for one, am not. In my opinion this Parliament has done a very good job of considering and carefully debating this legislation. The reports on VAD have taken many hours and much brainpower to put together. However, I believe there is a danger that

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by opening the door to VAD, we invite the possibility of reducing and rendering unnecessary the need to tolerate chronic illness, disabilities and the significant difficulties that some will endure at the final stage of terminal illness.

I am sure many members have read the *WAtoday* article published on 10 September. It was in the most-reviewed section for a few days. The article describes the experience of a disability rights advocate, Samantha Connor, who attended a rally at the Australian premiere of the film *Me Before You*. If members have not seen that film, I suggest that they go and see it because it is very powerful. Ms Connor is wheelchair-bound and some friends satirically rattled tins asking for donations to fund travelling to Switzerland to die. By her account, not a single person asked Ms Connor why she wanted to die or whether she was okay. The people who put money in her tin simply assumed that she wanted to die, and by doing so confirmed that they too would want to die if they were so unfortunate as to be in a wheelchair. No doubt these people thought they were being compassionate, generous and understanding, but did they consider what they were really saying to this group of people? A comment under this article, which I will not quote in its entirety, suggests that VAD should be available for those people who do not have “deep pockets” to pay for counselling and treatment, and that if it were available, a person could spare their family additional suffering. I believe this person also thought that their view was compassionate, but I am sure that all members can see the danger in this way of thinking and its implications if you follow it to its logical conclusion.

A number of polls, including one published in *The West Australian* of 26 August 2019, suggest that community support for VAD is at about 88 per cent. We have heard that said on many occasions. However, when we examine people’s views a little more closely, such as those of the person I just referred to, are we sure that we truly want to encourage and validate this view? Polls that have asked more detailed questions and asked people to consider the issue more carefully have produced far less overwhelming results. For example, the euthanasia and assisted dying Western Australia polling data collected by Sexton Marketing Group found that in the Mining and Pastoral and Agricultural Regions 75 per cent of people believe that palliative care should be improved ahead of legalising euthanasia. I certainly very strongly support that view.

Much of the debate on this bill has centred around supporting the idea of individual choice. It really is much more than that. The implications of this legislation go beyond the individual to the heart of our society. This legislation raises questions about how we deal with life and death, and the effect it will have on the most vulnerable members of our society and those who many of us might assume are not living an optimal life. If this attitude were to become even more common, how could we truly say that people will be making this decision free of coercion? The coercion may not be obvious or spoken, but it will be implied if our attitude towards the often difficult process of dying shifts towards the process being seen as unnecessary and a burden on those around us. I met with a doctor from Victoria who told me that coercion by the family is one of the worst things when someone says, “Mum, it’s up to you. You don’t have to live if you don’t want to.” I will not suggest anything more than that.

As a member for the Mining and Pastoral Region, where people have difficulty accessing basic health services, I know the provision of palliative care is completely inadequate. I do not feel comfortable making voluntary assisted death available if people do not truly have a choice between dying prematurely and receiving adequate palliative care on home soil. This brings me to a speech Western Australian Senator Pat Dodson made on voluntary euthanasia in August 2018. Although we come from opposite sides of politics, we both represent a very similar constituency, and it would appear we both have similar attitudes to voluntary assisted dying and on the impact its introduction would have on our state’s most remote regions. I would like to quote a small part of Senator Dodson’s speech. He said —

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.

I encourage members to read the whole speech, which is available in the commonwealth *Hansard*, to get a different perspective on voluntary assisted dying and how it relates to some of our most vulnerable citizens and people living in our regions. The member for Kimberley, Josie Farrer, also made important points about what needs to be done to improve the delivery of health services in the regions, particularly for Aboriginal people and people who live in extremely remote communities. I can say now that if this legislation passes, a lot of work will need to be done to ensure that there is adequate engagement with Aboriginal communities to make sure that it does not erode the delicate levels of trust that currently exist between health service providers and Aboriginal people living in very remote communities.

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Although I hold some philosophical concerns, I am primarily opposed to this legislation because I do not believe Western Australia provides adequate end-of-life care in our regions. I believe there is a need for far more work to be done to provide general health and palliative care services throughout the regions. Clause 4(1)(h) states —

a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in Western Australia and having regard to the person's culture and language;

My question is: as a state, are we providing the genuine choice required by legislation, irrespective of whether the person lives in Western Australia, having regard to the person's culture and language? I believe the answer is no. Considering the house voted to pass a motion in April, approximately six months ago, confirming this, it would appear that the majority in this place also believe that the answer is no. If not, what has changed so dramatically in the past six months?

Much of this debate has been framed as providing people with choice. I am sympathetic to the motive and I believe that people are generally capable of making their choice for themselves and that it will provide a comforting element of control over our lives. But I feel that this has been brought on without enough consideration of what is lacking in end-of-life care. If the state is providing a method of dying prematurely, I believe it must also offer every reasonable way of living well until the inevitable occurs.

We are close to stepping over a very significant threshold where the state will be responsible for administering a person's premature death without ensuring that we are providing people across Western Australia equal access to services and treatments. Is it really a choice if you have access to assisted dying, but not to comprehensive and good quality palliative care options? I also think the answer to that question is no.

In our regions, many people have to travel significant distances to access chemotherapy after a cancer diagnosis. They must also travel to Perth for numerous other health issues, sometimes even for straightforward procedures, and there are significant restrictions on what the patient assisted travel scheme will provide for. In the Legislative Assembly, the Premier gave a clear and compelling speech about his motivation for introducing this legislation. A point is raised by the Premier that I believe requires some focus. It was posed as a question —

If someone believes that life is sacred and it should never be ended before fate decides it, that is their choice. But for those who would choose such a thing, must everyone else be bound by your world view?

This question led me to reflect on the eloquent words of another Labor leader. Former Prime Minister Paul Keating wrote an opinion piece, published in October 2017, in response to Victoria's Voluntary Assisted Dying Act. I quote —

This is a threshold moment for the country. No matter what justifications are offered for the bill, it constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human.

I do not doubt for a moment the sincerity of the Premier's desire to provide choice and to provide a pathway to the relief of suffering. However, I feel as though the Premier's question is asking us as a society to take a step away from recognising the value of life—that the value of life is a belief held by only a certain cohort of people. However, it is a value that should, and I believe does, underpin much of what makes us a civilised society. Prioritising relief from suffering over the continuity of life, no matter how grim the outlook, may be something that many feel comfortable with. That is understandable when we are considering the real and terrible suffering that some will endure at the end of a terminal illness. However, it is our job as legislators to examine carefully not just the immediate implication of this legislation but also the overall and ongoing effect it will have on society. No matter our feelings about or intention to vote on this legislation, none of us can deny that we are stepping into very new territory. If this bill is passed, we will create a very small wedge that has the potential to open the door to broader application of euthanasia and a change in how we value the most difficult stages of our lives. I do not believe that this is a threshold we should cross and I will be voting against the legislation in its current form.

Of course, there are many questions to be asked in Committee of the Whole about the nitty-gritty of the bill: How will it be run? This is a state program but is it federally funded? I have gone through the memorandum of understanding but it was not clear on where the capital and funding will come from. One thing that has been put on the map, which is valuable, from the report and from debate in Parliament today is palliative care. One of the papers indicates that there has already been an increase in funding of millions of dollars to palliative care, and I think that is really important, but it needs more. This is a big state and we have only just started. When I met with carers in Broome some months ago, only five ladies were directly linked to palliative care. That is not enough. I look forward to the bill going through the committee stage.

HON DONNA FARAGHER (East Metropolitan) [2.35 pm]: I stand to make a few brief comments on the Voluntary Assisted Dying Bill 2019. This bill concerns issues that by any measure are the most important and the

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most profound that we as parliamentarians have been required to make a decision on. I know that for all of us it is a decision that is not taken lightly, irrespective of the decision we make.

At the outset I acknowledge the many Western Australians who have contacted me over the past few months by letter, by email, by phone and through meetings. Like everyone here, I have received thousands of emails both for and against this legislation. Perhaps for me—this is similar to views expressed by others already in this place, whether they have spoken in favour of this legislation or not—it is the hundreds of more personal letters and the many individual discussions I have had that have had the most impact, again irrespective of whether the individual was in support of or in opposition to the legislation.

I would like to thank the various medical professionals and specialists, including those at Bethesda Hospital, who answered my many questions and shared their perspectives, particularly in relation to palliative care. It is fair to say that for some of us, our views on this critical issue are not necessarily ones that are black or white, one or the other. I have listened closely to the contributions that have already been made in this house, the personal experiences that have helped shape members' views, as well as the individual stories that many people outside this place have been prepared to share with me. I absolutely understand how emotional and personal this debate is and why many in our community are so supportive of this legislation. Equally, I am conscious of the views that have been expressed by those in our community who have significant concerns, some of which I will share later, or who are totally opposed to this legislation. Irrespective of a person's views on this bill, it is my strong belief that the differing perspectives on this issue should be respected and should not be diminished, demeaned or condemned simply because it is a view that might not be held by someone else. I say that in the context of both sides of the debate. In accepting the arguments both for and against, it is incumbent on me and all members of this house to determine in all good conscience whether such legislation has all the necessary conditions and safeguards in place to enable a truly informed, voluntary and free choice to be made.

In coming to my decision on the second reading of this bill I have to be satisfied in my own mind that the safeguards that have been included are enough—enough to protect the vulnerable; enough for those who may have a voice but who have others around them who speak louder; enough for those with a disability; enough for those who may feel pressured, either intentionally or unintentionally; and enough for those who may feel that they are a burden to others.

I also need to be satisfied on the issue of the provision of palliative care, and although some will argue that this bill is not about palliative care, it is, in my view, absolutely linked. Can I in good conscience say that Western Australians irrespective of postcode are truly in receipt of comprehensive palliative care options? Am I sure that it is truly understood that palliative care is not necessarily a person's final care option in the last week or three days of their life, but one that can assist a person's journey over weeks and months, enabling them to die with dignity, as one palliative care clinician put it to me? Hand on heart, I cannot say that I am sure. I do not think anyone can. Specialists in this area have informed me of the various developments and advancements in palliative care over the past few years, yet access is certainly not uniform. It is not universally accessible. Indeed, the report of the Joint Select Committee on End of Life Choices said as much and this has been reflected in other contributions. The committee formed the view that there are —

... a considerable number of people with conditions considered amenable to receiving palliative care, but are not accessing it.

The committee stated clearly that accessibility of palliative care differs markedly across the state and found that access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients. The committee found that Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population. It also found that WA Health was aware of "the difficulties and shortcomings in the provision of end of life care". The department identified 11 gaps and challenges. I appreciate that the government has announced further funding for palliative care as recently as this week and that is a very good thing and is absolutely welcomed. But similar to other members who have talked about this, it is true to say that a number of my conversations with palliative care professionals have involved discussions about the adequacy of funding and resources, and I think we need to be very cognisant of those things.

I received an open letter from 150 medical practitioners opposed to this bill, which stated —

What is needed is the urgent correction of funding deficits in the provision of specialist palliative care and support services for those who are approaching their end of life. This applies throughout Western Australia but especially in regional and remote areas, including Indigenous communities.

The letter referred to the need to address significant service gaps, including increasing the workforce, and providing greater care or support services and hospital and community-based palliative care.

I hold other genuine concerns about the bill that have also been expressed by other members in this place, by members in the other place, by members of the medical profession and by members of the community. These concerns will

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have to be further examined and tested in Committee of the Whole. With all this in mind, ultimately it comes down to whether in my mind this legislation is truly safe and will protect the most vulnerable both now and in the future. I listened very closely to the comments made by Hon Alison Xamon before the lunchbreak in the context of people with a disability. As she knows, I agree wholeheartedly with the comments that she made. In this regard, I, like Hon Ken Baston, want to reflect on a letter that was written by disability advocate Samantha Connor, whom I have met on a couple of occasions. The letter was written during the debate on the Victorian legislation. I also appreciate that within the disability sector there are differing views on this issue. I respect and acknowledge that, but her concerns are not isolated and are certainly similar to some others that have been expressed to me. Her letter is detailed, and I do not intend to read all of it, but she raises a number of issues. She said, in part, as Hon Ken Baston related —

I listen to people talking carefully about safeguarding and the authority of doctors and I am terrified—not just for myself, but for the people in my community. You might not understand that, but that is because you do not know what we know. For us, this is personal.

This is why I'm afraid.

She continued —

In June, we joined with Australian and international protestors and protested the movie 'Me Before You' at a cinema in Perth. The film is about a quadriplegic who kills himself at a Swiss suicide clinic, despite having millions of dollars, a supportive family, the love of Emilia Clarke and a castle and jet. The message is that the lives of disabled people are not worth living, that you're better off dead than disabled. I took a prop tin that said 'Send me to a Swiss Suicide Clinic' and jokingly shook it at the nearest able bodied person— half an hour later, I was no longer grinning. Not one single patron asked me why I wanted to die—not a single person asked if I was okay. Not one person refused. Some people told me that they understood that I might want to die, because it would be terrible being a wheelchair user, and that it was 'my choice'.

It will, of course, be argued that the concerns raised in Samantha's letter and by others in the context of the risks to vulnerable groups, not only those with disability, are not relevant to the bill given the eligibility criteria identified in the legislation—the parameters that have been set and that the criteria will never be extended. Indeed, although the majority of the parliamentary committee agreed that the warnings about the impact of voluntary assisted dying upon vulnerable population groups should be taken seriously, it believed that the risks could be guarded against. However, can we be absolutely sure that an expansion of the eligibility criteria will never be considered one day when we in this place are long gone? I absolutely and sincerely hope that it will not. But I am not sure that we can guarantee that they will not one day be considered by a future Parliament, not made up by any one of us. No-one can give that absolute guarantee. Indeed, it was probably inconceivable years ago that Parliaments would be debating this very issue today.

I also never thought that I would quote Hon Paul Keating, but I do so today and I want to read a little from his opinion piece in *The Sydney Morning Herald* dated 19 October 2017. Although he was speaking to the Victorian legislation, it is relevant to this debate. He said the following in response to the claim that safeguards can be provided at every step to protect the vulnerable —

No law and no process can achieve that objective. This is the point ... once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law. And liberalised they will be. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible.

That is what worries me. In concluding my remarks, I have chosen not to retell personal stories or experiences that have impacted my family. Perhaps that is because it is too hard for me to do so. Perhaps it is because they are too personal and only for my family to share. But what I can say—and what I say with the greatest of respect—to the small minority of people who contacted me and indicated that if I and others do not support the bill we do not understand pain or suffering is that that is absolutely not the case. I respectfully suggest that no-one should presume that because someone has genuine concerns about the safety of people under this bill, they lack compassion, they do not care and they lack empathy and understanding of what it is like to be part of a bedside vigil, to be with someone who is so very dear and loved when they are in the final stages of life due to an advanced, untreatable and aggressive terminal illness. I simply ask: please do not presume that because you would be wrong to do so. I most sincerely recognise both sides of this debate. I completely understand and am truly accepting of the positions put by those who advocate strongly for this bill to be passed. But in all good conscience, and with the greatest of respect for those who have a different view, I do not believe that the bill can truly guarantee that the most vulnerable people will be absolutely protected by the safeguards and conditions included in the legislation.

I go back to where I began and to the questions that I put at the beginning of my contribution. Can I say in good conscience that Western Australians are truly in receipt of highly accessible and comprehensive palliative care

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options irrespective of postcode? No, I cannot. Am I satisfied that the bill before us has enough safeguards and conditions to enable people to make a truly informed voluntary and free choice in all circumstances? Are there enough safeguards to protect the vulnerable? Are there enough safeguards for those who may have a voice but have others around them who speak louder or for them? Are there enough safeguards for those with a disability, those who may feel pressured either intentionally or unintentionally, or those who feel they are a burden to others? I remain significantly concerned about the bill and I am genuinely worried.

I will conclude on this point. Yesterday, I spoke with a constituent who wrote to me and who kindly consented to me referring to her letter in this place. Her letter states —

Having watch my mother die at the age of 62 from cancer 6 years ago I know firsthand the issues surrounding “dying with dignity”.

She talked about her mother’s illness and her grief, pain and anguish. I do not intend to read that part of her letter into *Hansard* because that is her personal story that she shared with me. Towards the end of the letter she wrote —

People’s opinion on dying can change as they near the end of life. They may not be able to verbalise it though, and this is my fear.

...

If this bill is passed, I fear that over the years the laws surrounding the legislation will be lessened. I am very concerned for what could happen to vulnerable people and the older generation in the future if these laws are passed. Once this law has been passed we can never go back.

If I cannot provide a guarantee to one constituent that this bill will provide all the safeguards that are needed to protect the vulnerable, that there will not be one unintended consequence and not one wrongful death both now and in the future, I cannot in all good conscience provide that guarantee to anyone who seeks that reassurance. I therefore cannot support the bill.

HON SIMON O'BRIEN (South Metropolitan) [2.54 pm]: Members, so many of us are going to share personal reflections during the debate on the Voluntary Assisted Dying Bill 2019, and now it seems to be my turn. I do so having done a similar exercise on several occasions in the past. I take a different approach to this debate in my sixtieth year from the one I took in my 30s. My colleague in his 70s knows exactly what I mean because once again, we are forced to confront our own mortality. What would we do in this situation? I am sure that that thought has occurred to every single one of us as we contemplate the very serious matters contained in this bill.

My brother-in-law John Lowe was born 79 years ago. He spent a lot of time outdoors and maybe a couple of decades ago, he started to get skin cancers. He had bits of them cut off over the years and various treatments. But other things happened and things have got worse. I hope he will not mind me mentioning how bad things have become in recent years; how the cancer has caused parts of his bowel to be so dysfunctional that he now has a very annoying colostomy bag; how other cancers have manifested on his chest and people can see some up one side of his face; and how in the course of umpteen operations for different things, he has also developed dementia. In recent years, we have seen him slip away in so many ways. As we all know, dementia is a terrible thing. How much of them is there? Have they really in effect left? It is a very difficult thing for loved ones to come to grips with. But John has been dying and about to die for a few years now. A number of people, family and so on, have gone to New Zealand because they felt they needed to say goodbye. They have done that and he is still there. I went over a couple of weeks ago, not to say goodbye, but to do a range of things. The first thing I did when I arrived was hop in a car and drive 300 kilometres up north to see John, whom I had not seen for many years. I was prepared, as best as people can be prepared, for what I would encounter. Of course, my wife was with me because John is her big brother. It is a shock to encounter someone at that stage of life. They have been suffering for years—they are of advanced years anyway—and they have dementia. Are they really there? Do they know what is going on? Given all that, I found John was in chipper shape. He had the same independence of spirit that he has always had. Of course, we spoke about this afterwards when we were outside. What would his attitude be if he had been asked about this matter 30 years ago? I think he would have said what a lot of people say: “Gee, I hope I never find myself in that position” to which they might add the corollary, which I think a lot of us have probably said—“If I do, somebody please shoot me.” We have all heard that said if we have not said it ourselves, and it is said without really thinking through the implications. It is just something that is expressed. What would John say, Joy and I thought, if just for a moment he became lucid and was able to step back from himself? Would he say, “Gee, why haven’t you shot me”? I do not know. I cannot know. He exhibits a determination to keep on living—he really does. All of that strength he has shown all his life is still there. It is still part of his character. But if he were to want to say, “I’ve had just quite enough”, and you could not blame him, he would not be able to be helped by this legislation, because he does not have the capacity to make those sorts of decisions.

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I am not trying to out-traumatise anybody who has been good enough to share their own stories with the house. I mention that just to show that, along with other loved ones, that is my story of my brother-in-law at the moment. I want members to know that so that they also know that I get it. I understand the very strong emotions that drive the various participants in the debate that we are discussing now. I want members to know that before I raise my contribution to the debate, which I do now, in these terms.

We are debating the Voluntary Assisted Dying Bill 2019. In the course of this debate, I recall Hon Nick Goiran pointing out to us in his remarks that there have been many, many debates on euthanasia in many, many parliaments and assemblies throughout the world. Indeed, there have been several in this house alone in the last 20 years or so. On each occasion, virtually all of them have been defeated. We ought to think about that and why that has been the case.

Hon Robin Chapple reminded us of October 1997, when Hon Norm Kelly brought a private member's bill into this place. I was here for that debate and all those that have occurred subsequently. I know and have served with all the members then and since. I have listened to their stories; I have observed their demeanour. To the members of today, I would say this: please do not think that we are any wiser than those who came before us. Perhaps despite everything you have been told recently, those former members possess every bit as much compassion as we now claim motivates all of us; yet, on each occasion, the proposal for euthanasia has been defeated in this house. This time, the proposal is sponsored by government, major media outlets and a professional lobbying and PR campaign, and it appears set to succeed. The arguments, circumstances that brought the issue to prominence and calls for action are the same now as they were then. In 1997, euthanasia became an issue. The government of the day was asked whether something could be done to address the situation whereby a terminally ill person who was in great distress with no prospect of recovery or relief could voluntarily access euthanasia. It sounds very familiar. I recall that the Minister for Health of the day set out to inquire of doctors what needed to happen to address this public clamour. The answer from the doctors came back loud and clear: please do not legislate in this space. No ifs or buts. We had a discussion at that time, and it was interesting to hear Hon Derrick Tomlinson's contribution to the debate, which members may want to access, in which he talked about what some have referred to as terminal sedation, whereby the process for those facing their own end of life leads, understandably, to great emotional distress. Perhaps we all contemplate how we might react when given a terminal diagnosis, which, of course, in due course, most of us probably will receive. That causes great emotional distress. Also, the physical effects of a terminal condition may cause great pain that requires extraordinary measures to make it bearable. It often happens that people in end-of-life situations undergoing treatment receive narcotics for their pain, but also receive some antidepressant such as valium—I do not know what the up-to-date measures are—to help them with their emotional state. The combination of these two elements can relieve those symptoms for most patients, as I understand it, if not all; then, in due course, it can also have the effect of hastening the drawing to a close of the patient's life. I do not know that we would see that written down in any statute, but we were told that that is what happens. That is what happens, and that is what needs to happen. It is a matter for judgement and it is something that we cannot legislate.

I can tell members that the doctors as a lobby then and I think substantially now did not want the protection of law in dealing with patients in an end-of-life situation. They did not want the procedures that were to accompany it; they did not want their members to be killers; they did not want their members to maybe be compromised in their own values. Most importantly, they feared that the outcome of some form of regulation would be that end-of-life distress and pain-relief treatments would be less available to patients who needed it because of the advent of a slow-moving prescriptive legal regime that they would be scared to get on the wrong side of. That is the same prospect that exists right now. I sincerely hope that if this legislation succeeds in passing this house, while trying to provide end-of-life relief to a very small proportion of patients, as the proponents point out, it does not have the net result of denying end-of-life relief to a larger number of patients. That would be a terrible thing.

Here we are. We are involved now in another debate about this matter, yet again. Yet again, I wish to acknowledge through you, Mr Acting President, all those who have contacted me. I have over 600 emails that I have carefully put to one side. I have not been able to respond to them all, particularly as they have come in more recently, for and against, in different waves, but I acknowledge all those people now. I thank people who have taken the time to contact me and other members. I say to them: you have told me in roughly equal proportions for and against that you expect me to vote for your position. Sometimes, you have told me that with the extra encouragement that your future vote depends on it. It is something of a rock and a hard place, but I have been there before. I just want to say that I appreciate that this is an important issue for people on all sides of the argument. As I said in my opening story, believe me, I get it. What my constituents—rather fewer than the half million or so who are entitled to vote—may all be assured of is that I seriously consider the interests of all my constituents, whether or not they vote for me, when weighing up any provision that makes it lawful to terminate another person's life. Those same

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constituents, with their variety of views, also expect the Parliament to protect society from unintended and, in this case, lethal consequences, and rightly so.

Many health professionals have provided to members their testimony challenging some of the claims of the proponents and supporters of this bill. I have considered at length whether to engage in active debate about some of the arguments raised by activists and keen observers. I have decided not to do so, because I fear it would serve no useful purpose and might indicate a lack of recognition of or respect for the views that are so strongly held by people on all sides of the debate, and I do not want to do that. I do want to put forward, though, the arguments that need to be weighed by this legislature in enacting or rejecting a landmark measure such as the one that forms the core policy substance of this bill.

The core policy of this bill is a declaration of state approval that death is a valid option in medical treatment. That is what it is. Let us not sugar-coat it. It is a declaration that suicide or euthanasia is okay if things get too tough. I fear that the policy will create in the minds of many vulnerable people—the sick, the elderly, the dying, the depressed—a sense that they have a responsibility to die so that they will not be a burden to others. That is a policy of despair. I will not support it. There is also a view put forward by many that the policy contained in this bill is what the overwhelming majority want. Whether it is 80 per cent or 88 per cent or 188 per cent, I am not so sure that that is the case. I have received a number of submissions—members probably all have them—to which I have responded with great and genuine empathy about the circumstances of the individual correspondent, and I am advised that the provisions of this bill would have been of no use to their late loved one, just like it would be of no use to my brother-in-law John.

The provisions of this bill do not apply to many of the situations that many proponents of the bill fear, such as all those situations in which they say, “Gee, I wouldn’t want to end up like this. Gee, if I ever get to that situation, I hope you’re going to shoot me.” That is what the 88 per cent say when asked. If someone is in a terrible situation, if they want to, they should be able to access euthanasia. But for many of those people, the provisions of this bill would not apply. Therefore, that leads us to conclude, as Paul Keating has already said a number of times in this debate, that this bill is not going to be the end of the matter. It is only a first step and there will be pressure on future parliaments to extend these measures. It is a slippery slope indeed.

I have told members why I am not going to support the second reading. I have also indicated that I can count. I did not last this long in politics without knowing how to count numbers when votes are being taken, and I think this one might get to a later stage of consideration. I will turn now, though, to some comments on the actual bill. I will do so only briefly, but I will make some comments that need to be placed on the record.

One thing that worries me, and I will raise this again with members on other occasions, is what George Orwell would think about the way our society is heading. I cannot believe the way our world seems to be losing its sense of perspective, and I see so much of it in this bill. On other occasions, we can talk about whether our lives are being taken over by secret government agencies that are answerable to no-one. We can reflect on whether every move we make is being recorded on cameras and that all our digital footprints, as they call it, are being kept for posterity and ruminated over by others. We have seen plenty of newspeak as well, and that brings me back to this bill.

This bill is going to change the law in a number of ways, including that drinking a deadly poison to kill oneself is not suicide, and that killing another human being by injecting a person with the intention of ending life, in the circumstances that we are talking about, is not euthanasia. It will also put into black-letter law the prospect—I think it is quite a scary prospect—that when someone dies by poison, self-administered or administered by another, in accordance with the provisions of this proposed act, the death certificate is to say something else. What is the point of a doctor certifying death and signing something that is false? Surely that must alarm all members and others observing this. What is this world coming to? This is the Orwellian dystopia that I referred to just a few minutes ago. It is happening. It is scary and it should not be allowed to happen, but happening it is.

This bill does a whole lot of things, but there are a few questions that I will be seeking to ask, and I will give the minister some brief notice of them now. I will ask what happens in a situation in which a prisoner who has a terminal diagnosis—possibly a political prisoner or a garden-variety prisoner—is sentenced to a minimum term of imprisonment and their life expectancy is less than the sentence? Will they be allowed to kill themselves with medical assistance, or do they have to serve a minimum term first?

I have already mentioned clause 81 and the falsifying of a death certificate, and I will come back to that on another occasion. I, like others, would appreciate, minister, if I may, some discussion on clause 156, which relates to how this bill would interact with commonwealth law in giving advice and discussing what used to be called suicide, or assisting suicide, via telecommunication devices.

Hon Colin Holt: Carriage service.

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Hon SIMON O'BRIEN: Carriage service, as my old-fashioned colleague here reminds me that it is called.

Hon Colin Holt: Very technical.

Hon SIMON O'BRIEN: It is very technical. I thank Hon Colin Holt.

I notice that this bill has a lot of forms attached to it. By gee, it has a lot of forms. I thank the minister for the briefing I received from the relevant agency. I have a flow chart here. No wonder the doctors in 1997 said, "No, don't legislate for this." I am just running down all the forms. It is a pretty well set out diagram that I am waving around, which Hansard cannot record as such; it is quite colourful. It includes the first request form and possibly the coordinating practitioner transfer form; the first assessment report form; the consultation referral form; the consulting assessment report form; a written declaration, with two witnesses required; a final request form; and a final review form. That is the first phase. There also needs to be a contact person appointment form, and indeed multiple of those if there are later transfers of a contact person. There needs to be an administration decision and prescription form; an authorised supply form; an administering practitioner transfer form, if required; a practitioner administration form, if required; a notification of death form, if required; and a practitioner disposal form, if required. I must go back to clause 77 and find out what that is. Surely we are not disposing of practitioners!

Hon Nick Goiran: I think it's if there is substance left over.

Hon SIMON O'BRIEN: Of course it is; thank you.

There also needs to be an authorised disposal form. That is a heck of a lot of bureaucracy. No wonder, as I said, the doctors in 1997 were collectively scared off. There are a lot of things we can get wrong. Without any sense of flippancy, think about what we are talking about. It could not be more serious, yet we apparently have to have a bureaucratic solution. We are also told that there will be safeguards—not one or two safeguards, but 102 safeguards. What does that tell you? Is that a good thing? This must be a really safe bill. Here is a government scheme that is really watertight and foolproof. If so, it would be the first one I have ever seen. Having 102 safeguards does not make this bill watertight; it just shows us how many potential holes there can be. We have to ask the question: if the bill needed 102 safeguards, did it miss any? Maybe it needed 105. Maybe it needed 127; I do not know, but the stakes are pretty damn high.

Looking at the list of safeguards, all 102 of them—they are actually mostly not safeguards; they are various operating and procedural requirements—my attention is drawn now, as it will be if we ever get to the Committee of the Whole House stage, to matters of oversight. I have already alluded to my concerns about all these bodies being set up to run around and do their own thing, answerable to no-one. We have the Voluntary Assisted Dying Board. Dear, oh dear. It will provide an annual report to Parliament. Then what will happen? Who will make sure it is doing the right thing? There is also a provision for a review of the act, initially at two years. I will tell members now what that first review will say. It will say, "It takes a long time to get these processes up and running, so the act has not effectively been in operation for very long, so we haven't got much to tell you." The review at five years will be interpreted not as five years from the start, but five years after the first review. What will it say then? What will the review of the act say? What will be the criteria for deeming it a pass or a fail? Will it be how many people who died under these provisions were, upon autopsy, found to have been misdiagnosed and did not have the terminal condition that they were told they had? That has happened elsewhere. How many occasions, for example, will that be allowed? What is acceptable? If we were debating a law to say, "Let's hang some mass murdering eminently guilty beyond all doubt person whose continued existence on this earth poses a threat for the innocent", people in this house would be saying, "Ah, yes, but this is something that is too serious. If you made a mistake, if just one person was incorrectly convicted and hanged, that would be so bad that that would justify us not having this law." You know what? They are right. That is an appalling happenstance, almost too appalling to contemplate. Okay, what about the victim count under this legislation that so many in this house want to support? How many people? How many people will have to become casualties, as reported in the review of the act, before we deem it a failure? Will they just be collateral damage, as the American military would call it, or will zero be the acceptable limit? I do not believe zero will be the outcome. If the minister could give us his view on what the criteria will be for deeming it a pass or a fail—I anticipate it will not take long, because I do not believe that the government sponsoring this bill has given that a moment's thought—I do not think he will have any sort of satisfactory answer. Perhaps the minister could even tell the house that he just does not know.

I have some concerns about the way the bill is constructed, but overall, with all due respect to the officers who have been involved in creating it and to others, including committee members from this house and the other place, a great deal of work has been done and my argument is not with the processes that have produced the system as it has been produced; my argument is with the policy of the bill that required it to be produced, because I do not think it is the outcome that will serve Western Australia well at all. I think it will lead to victims and, most importantly, it crosses a key threshold whereby we will allow, with state sanction, a declaration to be made that someone's life is valued and that someone else's does not matter. If we adopt that as a policy, I think that would

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be a very sad day for the future of our community and our society. With all that in mind, and with all the respect in the world to those who are motivated to support this bill, I say with great respect that I am unable, once again, to support this measure, because it would be a bad law.

HON COLIN HOLT (South West) [3.29 pm]: I rise to give my views on the Voluntary Assisted Dying Bill. I have to say that the air in the chamber has been particularly heavy in the last week. It has been a very solemn debate. Obviously, it needs to be solemn and serious and everything we say needs to be taken seriously. There has certainly been heavy air in the chamber in the last week. I do not have any good jokes so I will not be telling any at this point in time. Maybe I will along the track in my contribution.

I first want to say to all members who have spoken so far that it has been a very interesting debate and, across the chamber, it shows the diversity of the views of our community and our society and their development. It makes the chamber richer for reflecting the views of our community. That is exactly how it should be. The other aspect is the respect for the variety of views. We should always maintain that, even though it gets a bit boisterous in here on occasion. However, the respect that can be shown for the different views is just as important as the content of the debate itself. I encourage that to continue, especially as we go into Committee of the Whole House, which I would think will be a long and arduous debate for this house. We will probably sit extended periods at some time. I am already feeling tired after a week. Once we get into the detail and the toing and froing of technical argument, it will be a real test for all in the chamber. I encourage members to continue to put their views, as I know they will, but with the respect they deserve and with respect for fellow members.

I rise in strong support of this bill. I do so after having been on a two-and-a-half-year journey, both personally and in a parliamentary sense. That journey has led me to strongly support this legislation. I have come to the conclusion that it is clear that this legislation is primarily about compassion. It is at the heart of my position and the heart of my decision to support the legislation. I put front and centre in my considerations the suffering of those people who are terminally ill and right at the end of their life's journey, because they are the people we are talking about here. They know they will die and are suffering to an extent that they define their position as being unable to put up with it any longer. My view is based on putting those people front and centre in this debate. Throughout my contribution and when I consider support for the bill and consideration of amendments that undoubtedly will be put forward, I will put those people front and centre in all my considerations. The people I believe want this legislation and this opportunity will be those who are at the end of their terminal illness journey, their cancer journey or whatever it may be, and finally want some relief in the way that they want it.

To reiterate that, this bill is for Western Australians—Western Australians who are suffering. We must continue to consider this. This is about our fellow Western Australians who we know are going on that journey. People will not qualify under this bill unless they have fewer than six months to live or 12 months for those with a neurodegenerative disease. They are at the end of their life and that is when they will want to pursue this option. We must remember that this legislation is also about choice—a choice for those who will meet the strict criteria. Although I agree with Hon Simon O'Brien, I do not think there are 102 safeguards, I think it is more about process in some of those areas.

Hon Simon O'Brien interjected.

Hon COLIN HOLT: No; I am paraphrasing him, if he likes. There are strict eligibility criteria and strict processes for people to go through. However, there is a choice all the way along the process, and we have to remember that. Not everyone will take up this option; it will probably be taken up by quite a small number of people. I do not know that we know what that will be. Certainly, the only real comparison we can make is with the Victorian legislation, although that act has been in operation since only July 2019. There are probably no statistics on it because the implementation of the policy in that state is quite recent. It will be an option for a narrow number of Western Australians. I think that is reflected, for example, in the bill, which is called the Voluntary Assisted Dying Bill. It is voluntary all the way along the process. People can make a choice whether to adopt it.

I completely accept the faith-based objections to that choice. I have absolutely no problem with them at all. I accept and respect that members may have a faith-based objection to accessing the voluntary assisted dying regime; that is fine. I think it is about people who want to access it, and that is why we are trying to pass this bill.

When I was on the Joint Select Committee on End of Life Choices, one thing that struck me with all the letters and evidence we got was that people really want to live. They go to extraordinary lengths to live for as long as they can to be with their family, their loved ones and their community. They fight and go through a range of medical treatments because they want to be cured and continue to live and be part of their family. When I think about who will apply for this regime if it is passed, it will be the people who are really at the end of their tether because they have a terminal illness and are right at the point of saying, "I've had enough. I've got no chance of a cure. I've been through all the options—chemo, radiation—and I'm now struggling. I'm bedridden and I'm in pain." It will be a narrow group of people. They are the ones who will be driven to take up this option for those

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reasons—they have had enough. Members, I hope that we in this chamber never have to make this choice and that we live long and happy lives and die peacefully in our sleep in our own beds, in our own homes, when the time comes. That would be a wonderful thing.

I talk to my mum quite regularly. She is 92 now and still living independently at home, but someone comes every day to check on her. She gets meals on wheels delivered and someone comes to help her shower and to clean her house. Living at home at 92 is pretty good going. I often sit down and talk to her. My latest conversation with mum has been probably a two-year conversation about residential care. We cannot force people to go into residential care, can we, especially when it is your mum? We have to have a conversation with her that takes her along the journey of thinking about it till we get to point at which she says, “Okay, let’s have a look.” That is how it has been. When we first raised it, she said, “I’m not leaving home; I want to stay here for the rest of my days.” Over about 18 months, we have come to the point of taking her to look at a few. That is the way it works with her. Whenever I go to see her, she always says a couple of things to me. One thing she says is, “Oh dear, I am getting forgetful.” I always say, “Mum, you are 92; you are allowed to forget things. I am 56 and I forget things. It’s okay; you can do that as long as you don’t forget to do the things you are meant to be doing, like feeding yourself, having a shower, getting up in the morning, being busy doing stuff and taking your tablets.” I had to organise Webster packs for her because she was doing it wrong and ended up in hospital. Another thing she always says to me is, “All I want, love, is to go to sleep one night and not wake up.” I say to her, “Guess what, mum. We all want to do that, but not all of us are going to be that lucky.” I think that is what this bill is about; it is about those people who are not going to be lucky enough to have the option of living until 92 and going to bed one night and not waking up in the morning.

I know that some of us in this chamber have already been unlucky enough to develop cancer and other illnesses that are and have been life threatening. We have heard some of those stories already. Many more people are facing the same situation. Luckily, members of this chamber and many people in the community get the expert treatments that are available. A person’s illness might be recognised very early; they get the right treatment, overcome the illness and continue to live the rest of their days. That is a good thing. Our medical system and medical practitioners are set up to assist people and to ensure that their illness is treated so that they can go on with their life. Our medical system works to sustain life. We know that there is plenty of evidence that not all of us are that fortunate. We know that some people with a cancer die and others do not. The Joint Select Committee on End of Life Choices gathered responses and took evidence during its inquiry and the evidence is clear. Undoubtedly, the letters, emails and notes to members of Parliament reflect heartfelt stories, which we have no reason to doubt, of people who did not get a cure and faced an early end to their life. That is just the way it works. Again, that is what this bill is about; it is about those people have not found a cure, are at the end of their days and are suffering. That is what it is all about. I urge members to keep that in mind during this debate. There is lots of noise and counterarguments, and bits and pieces are being pulled out of the debate that in isolation one thinks could be true. But taken as a whole and by focusing on who this legislation, policy and practice is for, it is clear in my mind that it is for those people right at the end of their life who want the option to hold their loved one’s hand and go out on their terms.

For members’ information, I was a member of this place in 2010, when Hon Robin Chapple introduced a private member’s bill. I think it was in my first year in the chamber. As a fairly new member, in my mind, it was quite confronting to be dealing with a bill of that magnitude. As a younger—a newer member of the chamber rather than a younger member!

Hon Robin Chapple: Why does age always come into it?

Hon COLIN HOLT: I am talking about my age not yours! I was a newer member of the chamber and I voted against the bill, but my views have changed. The reason for that was, in part, my journey with and commitment to the joint select committee and other things I have done. I would like to put on the record my involvement in the committee. I attended all committee meetings, with the exception of two or three hearings. The reason for that was that my plane from Albany was delayed—unscheduled and unwanted, that was for sure. It was a real shame that I could not make a couple of the first hearings because I think one of them was with the WA Country Health Service or maybe the Department of Health—I will have to go back and look at the records to check. It was a bit disappointing that I could not make the hearing, but obviously the transcript and video were available.

I also want to talk about some of the other things that I have done to inform myself about the debate on this issue before I came to any conclusions. I did a range of travel under my own initiative to explore the issue a bit more. It was never part of any official committee travel. I did it because I wanted to put some effort into the debate on the issue. In November 2017, I travelled to Melbourne with Amber-Jade Sanderson, MLA, who was the chair of the select committee. We met with the Victorian legislators and members of the Legislative Council’s Legal and Social Issues Committee. It is a standing committee; it was not a select committee. The committee had an inquiry into end-of-life choices. When we were in Melbourne, it was the last two days of the Legislative Council’s debate on

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the legislation. We purposely went to see some of that debate. We wanted to see how the chamber reacted to the debate, the level of scrutiny given to the bill and the government's interaction and response to it. We were there for two days. The Legislative Council had one all-night sitting, which I did not stay for, to get the legislation through. Amber-Jade Sanderson and I saw the debate, but we also met with the chair and other members of the committee. We wanted to find out the sort of process Victoria had gone through, because the Western Australia Parliament was embarking on its process for its legislative framework. I thought it was important to understand the sorts of issues the committee could face and to get a handle on the process it went through. It was valuable.

In 2018, I went to Switzerland and met with representatives of Dignitas. Members have mentioned Dignitas in the chamber before and probably will again. Dignitas is a Swiss non-profit members' society providing assisted, accompanied suicide to those members of the organisation who suffer from a terminal illness and/or severe physical and/or mental illness. The Dignitas society exists because there are no voluntary assisted laws in Switzerland and no laws preventing someone from assisting a suicide. The Swiss model is a completely different system. People do not often speak about VAD in the context of the introduction of laws because the Swiss model is completely different.

For a number of reasons there is no address for Dignitas on the internet. One reason is to maintain the confidentiality of people who access the service, because it is still quite controversial in some parts of Switzerland and Europe. Dignitas gave me instructions like, "Catch the number 6 train to such and such station and then get on the 34 bus. Get off at the third station, go around the corner and there is a double-storey house. We are on the second storey." The instructions were quite complex, but I got there in the end.

Hon Simon O'Brien: International man of mystery!

Hon COLIN HOLT: Yes, that is right. I had to ask someone in the end. Luckily, the Swiss speak English very well. I was told that I was in the right building but I had to go to the eighth floor. There were no signs anywhere.

I thought it was important to go to Switzerland to see what assisted dying was all about in that country. That was around the time that Dr Goodall travelled to Switzerland; he may have gone there just before that. I cannot remember exactly but I think he went there when the select committee met in its early stages. He may have been there three or six months before I arrived, from memory. The Swiss model was on everyone's lips because of what Dr Goodall had done.

When I was overseas, I also went to the Netherlands to hear from the people involved in the operation of its laws. I met with a number of different people and groups, including the NVVE, a not-for-profit pro-euthanasia organisation—probably a bit like our Dying with Dignity Western Australia. It plays the same sort of role in advocacy. My impression of the NVVE in the Netherlands is that it probably plays much more of a navigator role in its system. It is way beyond advocacy because it has probably moved into a different phase of where the law sits within its society. I met with the Dutch government authorities that are responsible for the operation and the monitoring of the act. I also met with representatives of the regional euthanasia review committees. There are a number of these in different provinces around the Netherlands. These committees assess whether a physician who has performed euthanasia or assisted suicide has complied with the due care criteria set out in The Termination of Life on Request and Assisted Suicide (Review Procedures) Act. One committee's role is to review how it is working. If I remember rightly, the membership is made up of a lawyer, a medico and an ethicist, which is really interesting.

Hon Stephen Dawson: What was that?

Hon COLIN HOLT: An ethicist. I am not sure how we define or find an ethicist. I think there are six or eight of these review committees around the country. Most of their members are academics from the university sector.

I will continue with what else I did to inform myself. In May this year, I went to Melbourne for the Victorian Voluntary Assisted Dying Implementation Conference. Obviously, the Victorian bill had passed, and it was going to kick off in July 2019. In May, the final bits of how it would be implemented was discussed. If I remember rightly, it was run by the Victorian nurses federation, and nurses obviously played a major role in the implementation of the service. Members may remember the Canadian doctors who gave a presentation here. They were also at this conference, giving their thoughts on the Medical Assistance in Dying Act, which they operate under, and the process they operate under as well. I really wanted to inform myself. I was always struck by the focus of this bill. I will come back to it because it is important to keep in mind that this is about Western Australians who are suffering from pain that they do not find acceptable at the end of their life. That will continue to be my focus throughout this debate.

The Joint Select Committee on End of Life Choices received submissions from a large number of people—800, from memory. We held about 70 or 80 hearings and heard from 125 to 130 witnesses. It was a wideranging inquiry.

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We received a lot of evidence from all sides of the debate and heard many different viewpoints. Again, we received a lot of evidence from people about their experiences of dying journeys.

There has been a lot of debate about palliative care provisions. I am the first person to say that we need more palliative care funding. In fact, a major recommendation of the joint select committee was for more funding and more services for palliative care. The committee clearly recognised the role that organisations such as Silver Chain play. One of the recommendations was to ensure further funding for those sorts of organisations. They recognised the need for increased hospice care in the northern suburbs. We also need more palliative care services in regional Western Australia, which I thought was really important. There is a glaring gap in those areas. It has been well documented that as soon as we get away from a major centre, the chances of accessing palliative care are a real challenge. People can be lucky to get the right palliative care nurse visiting their region or home or they may not be. We know that occurs.

Being a regional member, I already know and understand that there is a two-tiered health system. Every former and future government, not just this one, will have to face that challenge of a two-tiered health system. People living in Perth have a much better opportunity to access the health services they need than people living in regional Western Australia. That was reflected in the committee's report on palliative care outcomes. Although we welcome the funding increase to regional palliative care and palliative care generally, the opposition will be monitoring that and what it means for action on the ground. That will be the measure of that outcome. I am lucky enough to visit Albany regularly. It has one of the greatest hospices in the state. The people of Albany and the surrounding districts are well looked after. But we do not have to go too far from Albany to see that there will be limitations in the services delivered. Everyone will be watching that space. We need not only increased numbers of palliative care specialists in country areas, but also more dentists, general practitioners, cardiologists, oncologists, physios, nurses and gastroenterologists. If we are serious about providing services for those people in the bush, that is where it has to get to. We have to keep driving that as regional members and keep reminding the government about that.

I do not want to see the implementation of a voluntary assisted dying regime, if this bill passes, that makes that two-tiered system even worse. I know that there has been some discussion around some of the potential amendments to be put forward. We want to make sure that we double-check everything and put another safeguard in there. One of the amendments relates to referrals to a specialist, being the consulting practitioner. We have to think very carefully about that because of the consequences it has for country people. If one of the steps involves people needing to see a specialist who agrees to help that person on their journey, we have to keep a couple of things in mind. One of them is that they are ill and in the final days of their life, or a maximum of six months away from predicted death and in reality probably much closer. As I said, they are ill and they probably find it difficult to get out of bed. I am making some generalisations, so I ask members to bear with me. Once they have found their consulting GP, hopefully that GP is not a conscientious objector because they might have to go to a neighbouring town to find another one. Then, the second stage is that they have to find a non-conscientious objector specialist. They will probably need a referral from a GP to do that. Then people start to think that things are getting really hard. I think that is one of the challenges. We want to make sure that there are no wrongful deaths so we want a specialist in that mix, but we have to remember that that is one of the unknown consequences for regional people. I want to come back to a bit of that process down the track.

Earlier, I mentioned taking things in isolation. I want to give a demonstration of a journey that someone might go on in their treatment. I will tell a personal story about my own father. It is actually quite a good story and it really ended quite well—very well. In my mind, the story demonstrates a couple of very important things. People can correct me or they might want to add to those things, but I think the story reflects the typical journey of someone who is caught in the situation of being diagnosed with cancer. Again, members can make that judgement. This is just what I am basing my view on, because that is my experience of this situation. The thing I really want to show is that once someone is diagnosed with a potentially life-limiting illness, they have an enormous amount of contact with the medical profession, from GPs to specialists. They go back and forth between specialists and GPs getting referrals, blood tests, scans and biopsies. There is an enormous amount of interaction with the medical fraternity. That is exactly what happened with my father. Very recently, I was talking to mum and I asked her about his passing, because I wanted to explore whether she thought he had been in pain. Much to my surprise, she got out this notebook in which she had written everything that dad did at the time of his illness. In fact, there were a thousand things in it that were not even related to dad's illness. Things like when they bought a car or a new washing machine were written in the notebook. I have some photocopies of the pages that were pertinent. It is amazing. I said to mum, "We won't lose that." When mum goes, that could be the eulogy! We could read it out, because it is incredible. It is all mixed up—page 1 follows page 7 and then page 5! Anyway, I picked through the notebook and it tells dad's story from diagnosis to the end. I briefly want to go through the story, because it gives me context about when people are going to request this end-of-life consequence and journey.

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Dad was first diagnosed at 80 years of age with bowel cancer. That was in 2003. I have taken some of these things from mum's notes, but I have summarised them a bit so as not to bore members too much. On 27 February 2003, dad had a blood test identifying that something was wrong. Two weeks later he had a further test with the result saying he had a growth on his bowel. That was two weeks. Within nine days of finding that growth he had seen a colorectal surgeon and he had the operation to remove the growth. He spent two weeks in hospital recovering and was sent home. His prognosis at that point was very, very good. Things moved really rapidly once they discovered the cancer—really rapidly. In June that year, so a couple of months later, he returned to hospital for a week for a further operation. It was more of a fix-up operation to restore proper functioning, and people can conclude what that means. During that time, he was seeing both a cancer specialist and a surgeon. Even though he had a really good prognosis, he continued to go back to them. At that point, the prognosis was good and life had pretty much returned to normal. In fact, he had gotten back onto the golf course—he was going that well.

Two years after the initial bowel operation, in March 2005, he went back for a colonoscopy, and again the report was very good and there were no signs of any cancer. That was a great outcome for him. That was two years later. About a year later, in March 2006, dad again visited a colorectal surgeon after referral from his GP to see a specialist, because dad had been regularly visiting his GP. Mum has every date of every blood test in her book. He had a blood test that suggested that not all was right and in fact the cancer had come back. April and May 2006 were spent seeing specialists and having scans and tests. A scan revealed a spot on his lung, so he was referred to a cardiothoracic surgeon. More tests, more scans and more specialist visits showed cancer cells in the bowel, lung and liver. Then there was a trip to the hospital for more tests, bone scans and lung biopsies. Members can see the journey he was going on. He was in and out between GPs and specialists all the time. He was referred to an oncologist for treatment at that point, and I think we can see where this is probably going to go. Chemotherapy started in June 2006—dad was then 83—and over the next four months he had eight chemo treatment sessions, often staying in hospital for days at a time, and once he was in for two weeks to recover. By December 2006, he had been referred to a radiation oncologist and he received radiation on 29, 30 and 31 January 2007. Again, I think we can probably work out where this is all going.

In February 2007, he had a number of bone scans and a CT scan. In April 2007, they put him on a new treatment regime with the injection of irinotecan, which is a cancer treatment. He had three of those in April 2007. He was then 84 years old. He had his first diagnosis at 80 years of age and that was four years later. He had had two really good years, but things were going south pretty quickly. By 4 May, a decision was made for no more treatments and to carry on with his tablets, which were MS Contin, an opioid medication with morphine. At that point, the idea was to send him home and make him comfortable. Mum was basically in charge of dad's tablets. Mum's notes also show that on 9 August he started taking oxygen, because he had cancer in his lung and could not breathe so well. On 10 August, he started using a nebuliser, and then on 17 August, mum's notes say, "Increase MS Contin and continue to increase at dad's request." Basically, whenever dad said he needed another tablet, mum went and got it for him. That was done under the doctor's instructions and it was all sitting there, so that is what happened. As mum's notes show, he woke up on the morning of 18 August and asked for his morphine medication. Mum went to get them and by the time she returned at 6.45 am on 18 August 2008 he had passed away. She had that written precisely. The poor bugger. Mum went off to get his tablets and by the time she came back, he had gone. She immediately rang me.

The point of this is that, as we can see, his treatments went on for a long, long time. None of those decisions or treatments were ever done in isolation. Even giving more morphine was never done in isolation. He went through a range of treatments with a range of GPs, a range of scans and a range of specialists. It was not as though the specialist was introduced at the endpoint of his journey; he had been through all that. Everyone knew where the prognosis was heading. All these notes were there to say that is where we were heading and he had been through that whole range of things. I picked up a couple of important things from all that. Up until the point that they sent dad home to be comfortable, the focus of the medical intervention was around extending his life and finding a cure: "Let's have another crack at this one." Oncologists are pretty good at that: "Let's see how this medicine goes" or "We'll try this and see how you respond to that." He went through the whole gamut. He probably lost about 30 kilos by the end of it. He was not a tall man, as members can appreciate! By the end, he had lost quite a lot of weight. Dad was like all those guys from that generation—proud, independent and stubborn men who worked hard all their life. One day when I visited him, a nurse came to give him a shower. She could not turn on the tap. I had to turn the tap on because Dad had no strength. He was really embarrassed that I had to go into the shower while he was in there to turn on the tap, which is silly.

Until the point of being sent home, it was all about trying to find a cure. When the decision was made, "Go home and make him comfortable", it was all about palliative care and making him comfortable for when the time came that his heart would stop. That is the most critical decision point in what we are talking about. I honestly believe that people will go on the journey of finding a cure because they want to live for as long as they can. It is only when they reach the "send home and make comfortable palliative care phase" that this other stuff starts to come

Extract from Hansard

[COUNCIL — Thursday, 17 October 2019]

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up: “Okay. I know I can’t be cured. I’m shitting myself”—for want of a better word—“of the end and what it will look like. When is my comfort going to come?” Dad was extremely lucky because it seemed that the MS Contin had done the trick. Only he would be able to tell us how comfortable he was, but after talking to my mum, the consensus is that he was pretty comfortable. Obviously, he needed morphine to keep him pain free. But compared with the experience of people described in some of the letters that I received and some of the evidence taken by the Joint Select Committee on End of Life Choices, I would say he had a better passing than most. He was one of the lucky ones.

The palliative care that my dad received and the palliative care specialists were very good, even for 2007. Palliative care has come a long way in 12 years. The Silver Chain staff who looked after him were outstanding. Silver Chain has a long history of providing fantastic care.

When I talk about that journey and when I think about some of the potentially too-risky stuff—I am sure there are some potential risks—I always think about the outcome for a person in the last phase of their dying journey. It is just after that bit, “We can’t cure you” and it is about moving onto palliative care and making them comfortable.

As an aside, a series of amendments have been flagged by Hon Martin Pritchard. I want to put my story in the context of the journey that most normal cancer patients go through. The amendment I want to talk about deals with GPs initiating the discussion. I am of the belief that all the options should be on the table. If members think about my dad’s story, they will realise that it happened in different stages. When people first see a GP, they do not talk about the end point. The GP says, “There’s something wrong with your blood test here, mate. We’d better send you to a specialist to find out what is going on.” The specialist says, “Alright; let’s have a look at this to see what it could be. You’d better get some scans and biopsies and we will check it out.” The surgeon says, “I’ll tell you what we’ll do. We will fix this. We will operate and take the bit out and see how successful it is.” The conversation about palliative care and what happens at the end of life probably kicks in after a person is sent home: “We need to send you home. We can’t cure you. But we’ve got some options for you towards the end.” If we remove a GP’s ability to initiate a conversation about voluntary assisted dying, we take away an option for people when they are at their most vulnerable.

Debate interrupted, pursuant to standing orders.

[Continued on page 7890.]

Sitting suspended from 4.15 to 4.30 pm