

ACTS AMENDMENT (CONSENT TO MEDICAL TREATMENT) BILL 2006

Second Reading

Resumed from an earlier stage of the sitting.

HON NORMAN MOORE (Mining and Pastoral - Leader of the Opposition) [4.38 pm]: I said before the afternoon tea break and question time that the Acts Amendment (Consent to Medical Treatment) Bill 2006 is one that can create a lot of difficulty for members in determining how they will vote on the matter. As I was seeking to indicate to the house, members might have strong personal views on these matters, but, as legislators, they must take into account the strong personal views of other people in the community and should not necessarily seek to impose their views on them.

I have looked at the bill from two perspectives. First, the actual principle attached to the legislation - what is the bill fundamentally seeking to achieve? Secondly, what are the details of the legislation and how do those processes that are created by the legislation relate to the principle that is sought to be achieved by the bill?

The fundamental principle and the fundamental question that we must answer is: should people be able to prospectively make decisions about their own death in the event that they are unable to convey their wishes at the time when death is relatively imminent and seems inevitable? Mr McGinty, in his press release on this issue on 21 May 2007, outlined the intent of the bill as follows -

“Western Australians who are of sound mind should be able to make informed decisions in advance about what medical treatments they want to receive should they reach the stage where they are not capable of making decisions for themselves,” -

I have been asking myself whether we should introduce legislation to allow people to make those types of decisions. In her excellent address last night, Hon Helen Morton raised the question of whether we actually need to bring in this legislation, because it may be possible for people to make these types of decisions under the existing law. She referred in her address to common law practice in Western Australia, and to the program that is being conducted at Fremantle Hospital. As I have said, the fundamental principle in this bill is whether people should be able to make these types of decisions. In order to answer that question, we need to know whether people have the right to make those decisions now, because, if they do, this bill may be unnecessary and superfluous to requirements. However, if this legislation is necessary, the next question I ask myself is whether we should allow this principle to exist in our community. I have every intention of seeking to ensure that every possible effort is made to keep me alive for as long as possible. The prospect of being dead is not one that I contemplate with any relish. I would hope that every attempt is made to keep me alive for as long as is humanly possible. However, there are people who are comfortable with the view that they do not want to be a burden to their family or the community when their death is fundamentally inevitable, and who are prepared to make decisions about their death. Indeed, my dear mother-in-law, who was very ill, made the decision to stop taking her medication, and within two days she was dead. That was a deliberate decision that she made. However, it is a decision that, at this stage of my life, I would find very difficult to make. One of the problems with this bill is that what we may think at one stage of our lives may be quite different from what we may think some time down the track. I have never experienced such significant ill-health that I was ever in any doubt about whether I wanted to live or die. Therefore, I have never experienced the trauma that many people experience when they are heading towards death. In dealing with this bill, I am prepared on this occasion to agree that the law should give people the right to make those types of decisions. Again, as we heard last night, people may already have that right. I do not know. I therefore look forward to the minister's response on that issue, because it is important in the context of the second reading vote. What I am saying to the house is that if this legislation is necessary to allow people to make those types of decisions, I will support the second reading of the bill.

If the house supports the principle of the bill, the second issue that needs to be addressed is how advance health directives will be implemented within the community; in other words, how the system will work in practice. That is what I think most of the speakers in this debate so far have been concentrating on. I do not know of any members who have said they do not support the principle of the bill, although some members have indicated that they want to hear all the arguments and will make up their minds in due course. Hon Helen Morton went through the bill in some detail and explained what the various clauses of the bill mean and some of the difficulties that those clauses will create. Therefore, it is important that before we agree to the second reading of the bill, if that is what the house decides to do, the minister provides the house with some answers to the questions that were raised by Hon Helen Morton and other members who have spoken on this bill.

In my research on this bill, I have looked at a number of papers on living wills that have been produced by various people. It is acknowledged that living wills exist in many other jurisdictions around the world. I want to draw the attention of the house to a paper from a United States bioethics organisation called the Hastings Center. The paper is by Angela Fagerlin and Carl Schneider, and it is titled “Enough: The Failure of the Living Will”.

The paper seeks to demonstrate that in the United States, very few people have taken up the right to make a living will, and that so many complexities are attached to living wills that they should be abandoned. I will read to the house one interesting comment that illustrates why some people have concerns about the complexity of the processes for the writing and implementation of living wills. The quote is as follows -

Even patients making contemporary decisions about contemporary illnesses are regularly daunted by the decisions' difficulty. How much harder, then, is it to conjure up preferences for an unspecifiable future confronted with unidentifiable maladies with unpredictable treatments?

I will read that again, because it is very profound -

Even patients making contemporary decisions about contemporary illnesses are regularly daunted by the decisions' difficulty. How much harder, then, is it to conjure up preferences for an unspecifiable future confronted with unidentifiable maladies with unpredictable treatments?

No-one would doubt that that is the case, because we all know the multitude of contemporary illnesses that people are affected by, and the multitude of issues that doctors need to face in making contemporary decisions about those illnesses.

A living will asks people to work out what their preference will be at some time in the future, when no-one knows when that will be and what the circumstance will be, and when the person may be confronted by unidentifiable maladies and unpredictable treatments that may never have been contemplated and may not even have been invented yet. I have no intention of writing a living will, because I do not know how I would be able to deal with the issues that are raised in this paper.

The paper goes on to make the following interesting comment about a person's frame of mind when confronted with the decision to make a living will -

The healthy may incautiously prefer death to disability. Once stricken, competent patients can test and reject that preference. They often do. Thus Wilfrid Sheed -

This is a quote from an individual -

“quickly learned [that] cancer, even more than polio, has a disarming way of bargaining downward, beginning with your whole estate and then letting you keep the game warden's cottage or badminton court; and by the time it has tried to frighten you to death and threatened to take away your very existence, you'd be amazed at how little you're willing to settle for.”

That seeks to explain to somebody like me that whilst we are fit, healthy and well and not confronted with imminent death, we may well be prepared to say that we prefer death to disability. We may think that now while we are not confronted with an immediate problem of our life continuing. As we get closer to death and as it becomes more inevitable, people begin to say they would prefer the disability to death. Their attitude tends to change as they get closer to the inevitable. That quotation from that report is quite illuminating. It demonstrates one of the problems with living wills and how a person's thought processes operate when he or she writes one.

Today Hon Robyn McSweeney raised the issue of the proposed form for living wills that the government will produce. I think it will be done by way of regulation. A standard form that people can use, whereby they fill in the squares, will be created. I looked on the Internet to find out what the situation was in other places. On the FindLaw website I found a sample living will form from the United States. Before I go into the details, I want to say that living wills are obviously big business for the legal profession in the United States. They have as much to do with lawyers as they have to do with doctors. There seems to be a view in the United States that legal firms are promoting their form of living will and they want people to consult them when they fill it in and pay a fee. This particular living will comes from the law offices of Daniel E. Hanley in San Jose, California. I will not go through the whole document. I will read the directions that are contained in this sample living will. It states -

1. I direct my attending physician or primary care physician to withhold or withdraw life-sustaining medical care and treatment that is serving only to prolong the process of my dying if I should be in an incurable or irreversible mental or physical condition with no reasonable medical expectation of recovery.
2. I direct that treatment be limited to measures which are designed to keep me comfortable and to relieve pain, including any pain which might occur from the withholding or withdrawing of life-sustaining medical care or treatment.
3. I direct that if I am in the condition described in item 1, above, it be remembered that I specifically **do not** want the following forms of medical care and treatment:

Then it has lines marked A to K to be filled in. People have to work out what they want to write in there. I am no medical professional. To write down what people want done to them or not done to them seems like a very difficult thing to do. I seek leave to continue my remarks at the next sitting of the house.

[Leave granted for the member's speech to be continued at the next day's sitting.]

Debate adjourned, on motion by **Hon Ken Baston**.