

Dr Tony Buti; Mr Chris Tallentire; Mr Mark Folkard; Ms Cassandra Rowe; Mr Yaz Mubarakai; Mr Ian Blayney;  
Dr Mike Nahan; Mr Simon Millman; Mr Dean Nalder; Ms Josie Farrer; Mr Sean L'Estrange; Mr Kevin Michel;  
Mr Bill Johnston; Ms Jessica Shaw; Mr Peter Tinley

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## VOLUNTARY ASSISTED DYING BILL 2019

### *Second Reading*

Resumed from an earlier stage of the sitting.

**DR A.D. BUTI (Armadale)** [2.49 pm]: When we adjourned for the lunchbreak, I was talking about the doctrine of double effect. I said how it seemed somewhat strange to allow the doctrine of double effect to occur, but to not allow a tightly legally controlled voluntary assisted dying regime.

Now I will move on to some political philosophy and also reflect on religion and faith in this debate. English philosopher John Locke's social contract theory, which forms the basis of the constitutional structure of the United States, states that there is no right to commit suicide based on theological and conceptual grounds. Although this bill under clause 11 excludes the permissible act from being labelled suicide, let us for a moment accept the term. The basis of Locke's theological argument was a form of Thomas Aquinas' classic argument against suicide; that is, our lives are not ours but are God's property. But as Professor John Mitchell states, "However convincing one may find this argument, a faith-based argument can have no purchase in a legal decision in our pluralistic society." Mitchell was referring to the US, but Australia is an equally a pluralistic society. Locke's conceptual concern comes out of the nature of the social contract as a mechanism to protect property—in this case, the individual person. What Locke wanted to prevent was providing a theoretical basis upon which it could be claimed that individuals have ceded to the state the right to arbitrarily kill them as part of the contract. If one's life ultimately belongs to God and is not one's own, one cannot give it to the state as part of a bargain for social contract. But this again, as Professor Mitchell notes, is a theological argument that an individual's life is God's, and such an argument has no legitimate place in our legal arena, although I fully understand some people have a strong faith-based objection against voluntary assisted dying. What I say to them is that this bill will not compel anyone to act against their faith as it is voluntary. This also goes for doctors who can utilise the conscientious objection provisions of the bill to opt out of being involved in the voluntary assisted dying process.

Professor Sonu Bedi from Dartmouth College has postulated a justification theory when discussing liberty and democratic debate. He argues for a justification theory that limits the reasons and rationales on which polity may act. We need to turn to the democratic state's reason for acting. In relation to voluntary assisted dying legislation, it may be helpful to think about it via a justificatory constraint rather than the language of rights. Those who seek to limit our liberty to end our life must proffer a publicly available reason that is made in good faith. Currently, in most cases, the state permits terminally ill individuals of sound mind who would like to die to refuse lifesaving treatment or to remove a lifesaving tube, but the state may not allow the same patient to take drugs that will end their life. The state generally permits passive euthanasia but not active euthanasia or voluntary assisted dying. The Supreme Court of the United States relied on this distinction in the case of *Vacco v Quill* in 1997. The state of New York permitted individuals to refuse lifesaving treatment by removing a life-support tube that would end their lives. The state prohibited individuals only from being able to self-administer drugs to end their life. The Supreme Court reasoned —

Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.

But a justificatory constraint would push against this analysis. In both cases, we are concerned with a group of individuals who are terminally ill and of sound mind who wish to end their lives. The law allows these individuals to remove lifesaving treatment to do so but does not allow them to administer drugs to do so. If the reason or rationale here is to prevent harm to those who are terminally ill, one could argue that the state should prohibit both, lest it run afoul of the good-faith requirement of the justificatory constraint. So in banning active euthanasia or voluntary assisted dying but not passive euthanasia, the state may be operating on some conception of the good life. By allowing one practice but not the other, the state says that it matters how a terminally ill patient decides to die. If they decide to remove lifesaving treatment, that is permissible. If they decide to administer drugs, that is not permissible. That seems to be based on a particular conception of the good life; for example, a good life is one that ends by refusing treatment, not by administering drugs. That seems difficult to square away with a commitment to liberal neutrality. In effect, one could argue that a ban on voluntary assisted dying is a kind of morals legislation. Who is to decide what is the appropriate moral? One could argue that these kinds of laws are all based on a particular moral or religious view of the good life, failing the liberal requirement of justification.

[Member's time extended.]

**Dr A.D. BUTI:** Currently, we allow certain individuals—for example, the terminally ill and people of sound mind—to end their lives by refusing lifesaving treatment. A commitment to neutrality means that the law should allow them to end their lives by administering drugs as well; otherwise, we are privileging one conception of the good

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life—or in this case, perhaps, it is privileging one conception of the good death—over another. Then we could ask: why is one way a better or superior way to die, especially when voluntary assisted dying may cause less physical suffering than its passive counterpart?

I now move back to where I commenced my contribution, which was on the main themes of opposition to voluntary assisted dying. I now turn to look at whether there are adequate safeguards in this bill to protect the vulnerable. In the current bill there are 102 safeguards, but whether they are sufficient to protect the vulnerable is difficult to ascertain. That is why, although supportive of voluntary assisted dying and this bill in general, I await consideration in detail to see whether I am prepared to support all the clauses. The Leader of the Opposition articulated in a personal and eloquent way this morning how pressure can be expressly or implicitly placed on a person in relation to seeking to hasten their death. I do not think it will be possible to provide a 100 per cent guarantee against undue influence, but I do believe this bill can be improved, which I will outline shortly.

In relation to the vulnerable, those opposing this bill or similar bills often refer to mental illness, elder abuse and those with disabilities. But before looking at these vulnerable groups, let me briefly mention the First People, the Indigenous people of this state. Some concerns have been expressed that voluntary assisted dying is of concern for some Indigenous people and culturally a foreign concept. I would hope that dialogue can be continued with Indigenous people to allay their concerns and to ensure that the voluntary aspect is emphasised and protected. But I acknowledge these concerns, which I came across when working at the Aboriginal Legal Service of Western Australia in the 1990s. Before moving on, I should say I am not so sure about the bona fides of the Catholic Church's attempt to emphasise Indigenous concerns with voluntary assisted dying, as there are many other areas of Indigenous concern where the church has been missing in action.

This bill acknowledges concerns about possible impacts of mental illness on the end-of-life choices and as a safeguard, a person with only a mental illness will not meet the eligibility criteria. If the person's mental illness causes them to lose decision-making capacity, they will also not be able to access voluntary assisted dying.

What we need to do as a society is to work towards preventing suicide, and I know that the Minister for Health is keen to do so. The reasons people suicide are complex. There are a number of reported reasons for suicide, but legislation for voluntary assisted dying has not been identified as one of them. I refer members to a 2017 article by Lowe and Downie in the *Journal of Ethics in Mental Health*, which refutes the link and also criticises and discredits the 2015 article in the *Southern Medical Journal* by Jones and Paton that argued such a link. In the US, the five states that had the highest rates of suicide in 2015 were Wyoming, Alaska, Montana, New Mexico and Utah, none of which had legalised voluntary assisted dying. Oregon in contrast was ranked thirteenth. For the other states with voluntary assisted dying legislation, the rankings were: California, forty-fifth; Vermont, twenty-sixth; Washington, twenty-second; and Colorado, ninth.

When it comes to concerns about elder abuse and this bill, I say that we need to do more to prevent elder abuse and we should look at some of the work being done in some US jurisdictions to establish special prosecuting units to specifically deal with elder abuse.

I now turn to people with disabilities. When euthanasia or voluntary assisted dying legislation was being discussed in the UK and in Victoria, many people living with disabilities and their advocates expressed concerns. A poll done by Scope, a disability charity in the UK, showed that 64 per cent of people with disabilities were concerned about moves to legalise voluntary assisted dying. However, such a view is not universal, and UK Professor Tom Shakespeare, a person with a disability, said —

... there is already a right to refuse medical treatment. This means that people who are dying and are kept alive by interventions can refuse them, and die. Yet those who are dying but are not reliant on medical interventions still cannot control the timing and manner of ... death. This is surely unfair. Why should their only choice be to starve themselves to death? ... we are asking for in the UK: the same choice for a good death for people with terminal illness. It seems a contradiction that the disability rights movement campaigns for autonomy in every other area of life except this one, where it claims that dying disabled people are vulnerable and cannot decide for themselves.

Although I have some sympathy for and agree with Professor Shakespeare, I am still concerned about the bill and whether it may affect the vulnerable, be they elderly or someone with a disability.

I will now get personal. My eldest child has a disability. Her name is Alkira and later this year she turns 26. She is in many aspects a capable person. But whether she will ever be able to independently live by herself in the future is very doubtful. When I think of Alkira's future without me or Mandy, I get very anxious. I am very concerned as to what will happen when Alkira no longer has her mum or dad around. Unless you are in a similar situation, it is difficult to truly understand the anxiety we as parents have on that front. I would be much happier if society valued people with disabilities better than is currently the situation. I put out a challenge to members of the Dying with Dignity Western

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Australia organisation and all those who have been strongly advocating for this bill, including many of my colleagues in this house. The challenge is that when this bill becomes law, which I think it will, please then turn to directing some of your energies and compassion and love to improving the lot of people with disabilities in our society. Because right at the moment, we have a long way to go—and it starts with valuing people with disabilities more.

I am concerned that the bill does not prevent a medical practitioner from raising the issue of voluntary assisted dying with a patient. I am concerned that someone may take advantage of someone like Alkira and other people such as the elderly. The power imbalance between a doctor and patient, particularly one with a terminal illness, could be great. Many people are influenced by what their doctor says. I do not want to deny anyone the opportunity of dying with dignity or to not have a chance of rejecting a bad death, but I want people to self-initiate the discussion with their medical practitioner. I can see no reason for not inserting in the bill a clause that would prohibit a medical practitioner from initiating the discussion of voluntary assisted dying. If this bill becomes law, I think it is highly unlikely that the residents of WA will not know that accessing voluntary assisted dying is legal in this state. Thus, when considering the power imbalance between the doctor and the patient, I see no plausible reason for a medical practitioner to initiate the discussion. Therefore, I flag here that I am exploring the option of introducing an amendment to deal with my concern. But having said that, I believe that this bill should pass, subject to a thorough examination of the contents of the bill in consideration in detail.

This bill will give people in the last weeks or months of their life a real choice. Palliative care may provide relief for many at the end of their lives, but not for all. There are some circumstances in which pain cannot be appropriately managed. One of the issues that the bill does not outline is what we mean by mental capability or competence. I refer to a very good article by Cameron Stewart, Carmelle Peisah and Brian Draper called “A test for mental capacity to request assisted suicide”. Generally, the common law concept is in the negative in the sense that every adult is presumed to be competent and then has to prove that they are not competent. One could argue that when we are looking at providing consent for voluntary assisted dying, a stronger test should be in place. This article discusses what is needed. One example is for a legal test for competence to request assisted suicide. Firstly, the patient must be able to comprehend and retain treatment information regarding their decision to end their life. They should be able to understand and retain the extent of their illness, the available treatment, the available methods of dying and the risks of adverse effects on the method utilised. Secondly, patients must be able to weigh up the information and reach a decision. This requires patients to be able to reason by using information relevant to their decision to undertake voluntary assisted dying. The article then states —

3. The decision should be consistent over time with past expressed wishes and beliefs.
4. Patients must be able to communicate their choices and in cases where speech is difficult or impossible efforts should be made to find an alternative mode of accurate and reliable communication.
5. The decision must be free from undue influence. While patients will still be able to make competent decisions when they are highly dependent on others for care, their decisions must truly be ones that they have made, rather than decisions which they have been forced to make or feel they should make to relieve others of burden. Undue influence must be assessed by having regard to both the patient’s strength of will and level of pressure being placed on the patient by others ...

By legalising voluntary assisted dying—that is, allowing people access to medicines that will enable them to end their lives—for many, that in itself is a relief. As noted in the Victorian Parliament, in Oregon, approximately one-third of all people who are prescribed the medication do not actually take it. Every Western Australian should have the choice if they are terminally ill and comply with the criteria contain in this bill to end their life with reduced pain and suffering. It should be their choice, but it should be a choice free from pressure.

**MR C.J. TALLENTIRE (Thornlie — Parliamentary Secretary)** [3.06 pm]: Where do I begin a speech that is about the ending of life? In an ideal situation, we would not need legislation like this. But we know that we are in a human world, a world with all sorts of failings and a world of human frailty. There are times when we see people experience what we might call a good death. For some it is a quick death. For some it is a death when family are around and a sad occasion is shared and it goes with dignity and a sense of compassion. But for some, and we have heard the stories here, there are agonising deaths. There are cases in which the best palliative care in the world—acknowledging the advancement of the whole science of palliation—does not work for some types of illness. Maybe it will in the future, but there are some types of terminal illness for which palliation cannot nullify the pain. That pain is acutely felt by the person who is dying, but it is also acutely felt by those who are around—the family members. One concern I have is that for some, the enduring memory of the death of a loved one might be the images, the actual sounds and the whole experience of what may seem to be the agony of that person. I say “what may seem to be” because I have heard of cases in which the dying person was perhaps not in great pain. But to witness the event of that person’s passing was indeed an awful thing. Dying with dignity is what we are trying to establish in this legislation.

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I am thankful that we have had so much discussion in the community about this legislation. I regret that other pieces of legislation that impact on the lives of our citizens and all of us do not receive the same level of scrutiny. Just to draw one comparison, I think of the plight of homeless people—the whole homelessness situation in Western Australia—and the fact that somebody who sleeps rough is likely to have a lifespan 30 years shorter than someone would normally expect to have, yet we do not have the same level of policy and community discussion about an issue such as that. Fortunately, we have great interest in this issue. That is a good thing. I am encouraged. I welcome the fact that the community is actually observing us at work with this legislation, as difficult as it is. I appreciate that. The community is in fact sharing the challenges that we are all facing as we go through this.

It is important to quickly run through those essential things that set out who will be eligible for voluntary assisted dying. Obviously, it will be open only to people who have a terminal illness and who, in all probability, will die within six months, or 12 months in the case of neurodegenerative disease. The person must have decision-making capacity. This is an important point to touch on, because it has to be realised that that will rule out many people who are suffering, in pain, very frail, very elderly and have a terminal illness, but who will be deemed to not have decision-making capacity. I think especially of people with some form of dementia; they will not be able to be involved in this process. Voluntary assisted dying will be open only to people over 18 years of age who are experiencing a pain such that their suffering cannot be made tolerable. I think those criteria actually do confine things. When I have consulted experts about this and asked how many people a year we expect to die in this way, the estimate seems to be around 50 or so people. The legislation will have limited scope. I am actually thankful for that. I think the only way this legislation can proceed through this place is by applying it in a tightly confined way that can make it acceptable.

I will give some of the reasons I have had concerns about this legislation. Eleven years ago, when I first got into Parliament, there was discussion that a bill could potentially come on for debate. At that time it was put to me that palliative care would be able to cope with most cases of terminal illness. It has really been an awakening for me to find that that is not always the case. I wonder whether sometimes there is an element of people assuming what people who are dying want. I often hear people say, “I’m so sad that my husband or partner died without any of the family being around.” I am not convinced that at my final moment I will necessarily want other people to be around, but there does seem to be an assumption that we do want people around as we leave this world. I worry as well that there will be potential for people who are just fed up, who have had enough of life and who are perhaps suffering from some form of depression to in some way be included in this end-of-life process. I am encouraged, as I study this legislation, that I do not think that is the case.

I do not know the man’s personal circumstances, but one high-profile voluntary assisted dying case was that of Dr David Goodall, who went to Switzerland to die. So far as I could tell, Dr Goodall had a lot to contribute. This was a man who was giving interviews as he was getting onto the plane to go to Switzerland. For all I know, he could have been in a condition of unbearable suffering—far be it for me to judge.

I worry about the notion, as others have touched upon, of people having a sense of being a burden. I have worried about that. Again, I think the parameters of this legislation guard against that. That is when we come to the whole process by which someone needs to ask for voluntary assisted dying three times, and for one of those times to be in writing. They need to be examined by two doctors, who have had all the necessary training and who are capable of judging whether coercion is involved—they will have been trained to see whether somebody has just been subtly somehow convinced that they are a burden. The medical advice I have received from those who work with people in this situation—those who work a lot in nursing homes—is that, if anything, the coercion is only ever the other way, and that it is family members who are trying to convince an aged relative that they should hang in there, keep fighting and that somehow the medication is going to start working and they will feel better. A very complex, emotional whirlpool of events and feelings are going on—all sorts of emotions are involved. That is when it is critical that our legislation be as clear as possible and that it guard against any of those misuses, if not to say abuses.

I want to say a little about palliative care and express my gratitude and respect for all people who work in that area. I recognise them as dedicated professionals. For many, working with the dying is a vocation. It is much broader than the mere prescription of opioids. It is all about counselling, nurturing, relationships with family, encouragement and empathy—all those things that make up good palliative care. It is much broader than the simple prescription of opioids. We have had the discussion that more can always be done for palliative care. Of course, like everyone, I support that. I heard one statistic that Silver Chain is currently funded for about 400 patients but in fact has 650 patients it would like to deal with. Those sorts of things can be resolved; it is simply a matter of us finding the financial will to do it.

My final point on the subject of palliative care is that we have to see it as part of the end-of-life process—that palliation is something that someone will go through and then, at a given point, they may well choose to use voluntary assisted dying means. That, to me, is a reflection of how our health services are evolving and of their sophistication.

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The issue of how someone dies needs to include the feelings of the loved ones of the dying person. I think that is a very important consideration in all of this.

I hear a lot in this place about the use of things like advance health directives. I applaud the Minister for Health for the announcement today—I heard the ads over the last couple of weeks—about people choosing the circumstances of their death and thinking about it. It is about getting this conversation happening. Here is another, if I can say it, benefit of this legislation coming to this place—we have really got the conversation going in the Western Australian community about death. That is something I have never seen before and something that I, myself, have never been comfortable with before either. This in itself is great progress. However, one thing that cannot be included in an advance health directive—this will be in the legislation—is that people cannot say that in certain circumstances they want to be able to take the so-called goodnight pill. That cannot be included in the advance health directive. I know that some people will be disappointed with that, but it is essential, because it retains the integrity of the very important point that that is something that must be requested only when someone with a terminal illness has six months to live, or 12 months if it is a degenerative disorder. The thinking around that provision is really solid. I fully support it.

I touched on the independence of doctors and acknowledged that some doctors will not want a bar of this. They will not want to be involved and they have every right to say that they do not want to be involved. However, those doctors who are involved will be required to go through a mandatory training course. They will have to demonstrate that they fully understand the legislation. They will have to judge the capacity of the dying person to make that decision. Of course, as we have said before, they will have to be able to detect coercion. It sounds like quite a broad skill set, a very important one, but I am sure that it is one that we can ensure is well entrenched in the system. There is an important role for the oversight board, which is not a body that just gathers statistics; it is involved in every stage of the process. I know there is some discussion about how long that process can be and that it can be as short as nine days in some cases; nevertheless, that oversight board is involved. That is also a strength of this legislation.

I want to come back to the point I touched on earlier that we as members of Parliament get the opportunity to visit constituents in nursing homes, and sometimes that can be quite a grounding experience. We meet people who are in a very frail condition physically, and quite often they are not particularly mentally strong as well. It is probably the case that a lot of the people we see in those high-need facilities will not be able to access this whole process.

In preparing for debate on this legislation, I sought advice from some faith leaders in my area. One conversation in particular I had was with Catholic priest Father Philip Pierrot, a lovely man. We agreed that whatever transpired, we would maintain a strong friendship following this legislation. He put to me that he was concerned about the subtle nature of some versions of coercion, and that that was something he was particularly worried about. He was also worried about the potential for this to be seen as inconsistent with our strong messages around and our investment in the issue of suicide, and the community's concern around suicide. Those of us who have studied this more closely can see that the two things are very different; there is not a connection. However, there is a concern that there is a false equation in the broader community. At times I heard messages about the redemptive power of suffering, the purifying virtue of suffering and such things, but I think those are some of the older ideas that we are moving on from.

I want to touch on the issue of the Hippocratic oath for the medical profession. This is something that is sacred to medical doctors. The oath was devised nearly 2 400 years ago. We can well imagine how much society has evolved since those original words, very worthy words, encapsulate the idea that a physician must treat the ill to the best of one's ability, preserve a patient's privacy, and teach the secrets of medicine to the next generation. They are wonderful ideals that are sometimes put up as an argument to say that therefore the doctor could not possibly be the person who oversees or administers something that will terminate a person's life. That is a valid point.

[Member's time extended.]

**Mr C.J. TALLENTIRE:** However, I point out that civilisation has evolved. We have seen the near phasing-out of slavery and we have seen a dramatic change in the attitude of society towards women, to name just a few things that we have now as hallmarks of a civilised society. I think, again, that we can see that there needs to be an evolution of something as important, and indeed as sacred, as the Hippocratic oath. When I think of the death of loved ones whom I have been close to, I have a sense that the need for people to be around at the final moment was not something that occurred, maybe through bad luck or perhaps through the wishes of the dying person. That is an interesting one. I contrast that with an amazing film from 2003, *The Barbarian Invasions*, a Canadian film that tells the story of someone going through to the final moments and having the family around them as they passed away. It was a beautiful heart-wrenching moment in that film, but a very well-told story.

I commend the general tone of this debate in not only this place, but also the community. What I have witnessed has been very respectful. The last forum I was at was in Kelmscott and was hosted by the member for Armadale and Hon Matthew Swinbourn. We had the pleasure of having Dr Scott Blackwell and Dr Michael Gannon debating

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one another. It was a very respectful, useful and informative debate. That is something from which we can all take inspiration as we continue to go through this important legislation. I also thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying, especially Malcolm McCusker, and the member for Morley, the chair of the parliamentary select committee, and all the people who made submissions and engaged with the deliberations of the various committees. This legislation is ultimately about someone having the choice to not endure the pain from an illness that is going to kill them. I support this legislation.

**MR M.J. FOLKARD (Burns Beach)** [3.28 pm]: I rise to support the Voluntary Assisted Dying Bill 2019. Before I start, I thank other members of this house for their fantastic contributions and for the sad, heartfelt stories they have relayed in their speeches. In this debate I have seen the very best of us in this place. I thank our Premier, the member for Rockingham, for his comments early in the debate regarding first responders and the difficulties they face day to day when dealing with this difficult topic. As members are aware, in a previous life I was a long-term serving senior police officer. My values and thoughts on voluntary assisted dying have come about through many years of attending countless sudden death scenes that related to people passing from chronic illness. I have attended so many over the years that I cannot even begin to quantify the numbers. I have attended murder–suicides when partners have killed sick loved ones and then taken their own lives. I have attended scenes when partners have attempted to kill their sick loved ones and then taken their own lives, but have failed in taking the life of the sick partner, resulting in that partner dying in loneliness.

I have attended scenes when a partner has taken the life of a sick loved one but has been unsuccessful in taking their own life and has become nothing more than a living vegetable. I have seen simple suicides after individuals have been advised that they have a terminal illness. Some have jumped in front of trains. I have even been to situations in which individuals have created complicated machines and used them to take their own lives. I recall one situation in the wheatbelt in which an individual, upon being advised that he had terminal prostate cancer, built a machine. He rang the police, put himself in the machine and took his own life. The instrument he developed was such that once he put himself into it, there was no way of getting out of it until it completed its tragic task. The individual knew that it would take the police 40 minutes to get him but that the mechanism would complete its horrific task in 20 minutes. I had forgotten about this and only remembered it recently when I was thinking about and preparing for this second reading contribution.

I have also attended palliative care situations in which palliative care sedation has led to the death of an individual and a complaint was made that hospital staff murdered the dying patient. The complaint came from an aggrieved family member who felt that he was not involved in the care of the dying person and that, in his opinion, his views were not taken into account before the final stages of sedation took place. I have investigated circumstances on behalf of the coroner and I have supervised investigators on behalf of the coroner. I have cried with officers who have been overwhelmed in those circumstances. As a country police officer, I have held loved ones in my arms and shed tears with them as they have come to terms with the passing of their loved one. These people were strangers to me, but they sought my console and being the only person there, I did what was needed to negate their suffering. I doubt that no-one in this house has seen more death, more deceased persons or more tragedy in relation to this topic than I have, with the possible exception of the member for Kalgoorlie, who was also a long-term police officer.

My view on voluntary assisted dying formed over many, many years, before the Joint Standing Committee on End of Life Choices parliamentary inquiry, before the Ministerial Expert Panel on Voluntary Assisted Dying, before the consultative process I ran in my electorate, which involved extensive cold-calling, doorknocking and meeting with constituents, and before the end-of-life forum that I held at the Joondalup Sports Association in Iluka. I noted from the recently published survey that at least 90 per cent of people in my electorate—possibly as high as 95 per cent—support voluntary assisted dying. But my views were developed through real-life experiences. It is interesting that with all the years of working in and dealing with these tragic circumstances, the real driving issue behind this is fear. I say that again: the real issue is fear. Let me explain this. It is not a fear of death; rather, it is a fear of suffering through the process of dying. The best example I can give is the recent conversation I had with my father. My father is a Vietnam veteran. He was a past member of the Special Air Service and served in Vietnam. He was in the field when the Battle of Long Tan was fought. Some would say that he is a very brave man, and I would agree. He is not scared of death—but he is terrified of suffering when he is dying. He has pleaded with me on numerous occasions that if I have a choice, he would prefer that a decision be made at the earliest point rather than allow his suffering to continue. This fear was evident during a recent home visit to discuss this topic with an elderly couple in my electorate who are in their 90s. They are a lovely couple, so proud and full of life, but they are so concerned and worried. When it comes to their final journey, they want to have control and maintain their dignity when the time comes.

I must note that during all the consultative processes that I have conducted about voluntary assisted dying, as a general rule the discussions have been mature and in good standing. Some nasty things have been said, particularly in emails that I have received from lobby groups. They do not deserve a response. What really worries me is the experience

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of real anger because this legislation does not go far enough and does not cover dementia or Alzheimer's disease. I recall talking to a particular gentleman at his doorstep. He was very passionate about the topic and it became clear to me that he had genuine fear in his eyes; it was obvious from his tone and the language he used when he spoke to me. I had no answers for him. I took his views on board.

I have not ignored the religious views of my constituents. I took the time to speak to Kay Goldsworthy, the leader of the Anglican Church of Australia, to hear her views on this topic. They were very interesting. I sought out senior members of the Western Australian Muslim community and spoke to them about this topic. Again, their comments were very interesting. Having been raised as a Catholic, I know that Muslims' views are very similar in some ways. They view this as one of life's challenges and they believe that how individuals deal with it is their choice. That is very similar to the view of the Anglican Church; the Anglican Church's views are very mature. I found solace listening to these individuals.

The second group that approached me that opposes this legislation is the palliative care lobby. I really worry about that group. In addition, I really worry about palliative care in Western Australia. Voluntary assisted dying should be part of an individual's life-ending choices and should be included as part of their palliative care plan. Over many years of dealing with the fallout of chronic illness, I have formed the view that palliative care is only for the rich. In the report "My Life, My Choice: The Report of the Joint Select Committee on End of Life Choices", I read with interest finding 9, which states —

Access to inpatient specialist palliative care in Perth is limited.

Finding 10 on page 67 states —

Apart from a small number of private beds at Glengarry Hospital, there is no inpatient specialist palliative care hospice in the northern suburbs of Perth.

This concerns me. During the briefings I received on this legislation, no-one could tell me how many palliative care medical specialists are in Western Australia. I was told 15 or possibly 19, but no-one could accurately tell me how many specialists we have. The area of Western Australia comprises 2 529 875 square kilometres, with a population of approximately 2.72 million people. That means there is one doctor for roughly 182 000 people who are spread around 180 000 square kilometres. I served extensively in regional WA. In nearly 30 years of policing, I have no recollection of there being any palliative care doctors in regional WA. I have a real concern that regional people are restricted in their end-of-days options. Western Australia's regions are divided into seven health districts, and each region, if divided equally, is around 360 000 square kilometres. My understanding is that possibly two palliative nurses cover those districts. With such limited numbers in an area of such a great size, there are clearly some major issues.

I have also read with interest about the major issue that our oncologists have such little faith in the palliative care specialists that they are not referring people to these specialists at the earliest opportunity. I wonder whether that is because there is not enough of them or they do not have any of them, or whether it is because they are only in the metropolitan area. I note that in the northern corridor, the only inpatient palliative care available is at a private hospital in Glengarry. This reinforces my thoughts that palliative care depends on the thickness of your wallet rather than the needs of the individual. Further, I note that the thicker your wallet, the easier it is to access these services and the closer they are to your home. On my review of the sector, and what limited service providers there are, I found that they are generally located in medical infrastructure rather than out in the local community. They are all focused on the metropolitan area, where medical services such as MRIs, pharmacists and oncology services are co-located, and the likelihood is that they are closer to where you live if you live in the metropolitan area. This is a concern that clearly demonstrates that the more isolated or the poorer you are, the less likely it is that you will be able to receive proper palliative care, and the less likely it is that you will receive it at all. The further you are away from the city, the less likely you are to get good proper palliative care or supervision.

We really need to do better in this place. I see that this government has committed an extensive sum of money to try to rectify some of this, but I think there is a long way to go. Earlier I stated that I have done some investigation into palliative care in hospitals and hospices. During those inquiries, the term "palliative care sedation" was raised. This is not a new term. This is when palliative care teams start increasing medication to ease the pain of the patient. The medication is increased to reduce suffering, but it is increasing the medication that eventually leads to the patient's death. It was interesting speaking to nurses during my consultative processes because on several occasions these different nurses stated that they, through the palliative care process, could tell a family almost to the hour when a person was about to die. This, to me, seems to be effective euthanasia by another name. It was unsupervised, there were no checks and balances, and the possibility of abuses in that process were clearly evident to me when dealing with the situations I had previously dealt with. It is something to think about when there is a royal commission into elder abuse in this country. I watch this space with interest to see what its findings will be.

**Extract from Hansard**

[ASSEMBLY — Thursday, 29 August 2019]

p6127c-6161a

Dr Tony Buti; Mr Chris Tallentire; Mr Mark Folkard; Ms Cassandra Rowe; Mr Yaz Mubarakai; Mr Ian Blayney; Dr Mike Nahan; Mr Simon Millman; Mr Dean Nalder; Ms Josie Farrer; Mr Sean L'Estrange; Mr Kevin Michel; Mr Bill Johnston; Ms Jessica Shaw; Mr Peter Tinley

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I read with interest that there are 102 checks and balances within the Voluntary Assisted Dying Bill. I hope that these will counter some of the arguments put against an individual's right to die. This bill is about empowerment. I say that again: it is about empowerment of an individual when it comes to their time to die. Canada has had voluntary assisted dying legislation for at least 10 years and possibly longer. When a couple of practitioners came to our Parliament to speak, it was interesting to learn that it was their experience that of those individuals who were firstly administered the instrument of their final choice, one-third of them who qualified for the end-of-life choice chose not to administer that instrument. This, to me, is evidence that voluntary assisted dying is more about an individual's right to choose, and, more importantly, that they have ownership of the way that they want to pass.

Voluntary assisted dying is about owning your own journey. It is about knowing the when, the where, the how and the who. The “when” is to know the time you are going to pass; the “what” is about what is going to happen, so that you fully understand the process, thereby empowering the individual; the “how” is knowing what is going to happen and knowing that not some third party, but you, have control; and the “who” is about who has control of your final journey and who is around you when it happens. Over the years I have worked with many inspirational people and leaders. Some of them will always be nameless and faceless. One of them whom I would call a wise man once said to me that the best way to combat fear is through empowerment.

[Member's time extended.]

**Mr M.J. FOLKARD:** I believe the reason there is such wide support for this legislation is that our community believes that when it comes to dying, everyone has the right to decide the direction of their final journey and how that journey will take place. This bill attacks the fear that is associated with the current horrific passage of passing. This bill empowers an individual so that in certain circumstances, they will own their final journey. It is their death. I believe my community believes that that should be the case. I commend the bill to the house.

**MS C.M. ROWE (Belmont)** [3.45 pm]: I rise today to speak in favour of the Voluntary Assisted Dying Bill 2019. Arguably, this is one of the most critically important bills that we are likely to deal with in this place. Firstly, I acknowledge the hard work of the Minister for Health and congratulate him for introducing this historic legislation. I also acknowledge the hard work of the joint select committee, especially the member for Morley for chairing the committee, and, of course, the ministerial expert panel. I can imagine that the last two years have been an incredibly challenging and emotional journey to get through.

Like all of us in this place, I have delicately considered my position. I have received letters, emails and phone calls from people right across my electorate who have bravely shared their stories, like so many here today, and told me their view on this very sensitive issue. I conducted a number of surveys. One was online and then I mailed out surveys to my whole electorate. I hosted a community forum because I wanted to make sure people of all different views in my electorate had the opportunity to come forward and share their opinions with me on this particular bill. Overwhelmingly and probably not surprisingly, like everybody else has mostly experienced, my constituency is overwhelmingly supportive of this legislation. I support this legislation wholeheartedly as well, because, ultimately, at its heart, this bill is not about dying; it is about dignity. It is about compassion and, most importantly, it is about reducing suffering. I am exceptionally proud to be part of the Labor government that is bringing this bill to the state Parliament, but to be clear, I respect those who do not share my view on voluntary assisted dying.

I would like to take this opportunity to acknowledge the contribution of the Leader of the Opposition, who earlier today reflected on her very personal and painful experience of watching her husband die of cancer, as well as the member for Bicton for sharing her heartbreaking contribution, along with many other contributions that we heard yesterday and last night. Your loved ones would be really proud, and I know that it has been tremendously difficult for people to share their heartfelt experiences.

This bill is not about suicide. Voluntary assisted dying is not suicide. This bill is about giving those who are diagnosed with a terminal illness—when they are likely to die within six months, or 12 months if it is a neurodegenerative condition—a choice about the way in which they die. It is about providing patients with autonomy over what should be their most fundamental right, in how they die.

In 2017, the state government established the Joint Select Committee on End of Life Choices. As we heard from the chair and many other members of that committee, it was an exhaustive process, embarking on extensive consultation right across the state. It received 700 submissions and heard from 130 witnesses. The work that the committee conducted was really critical in the formulation of this legislation that is now before this place.

This bill enshrines the right of a terminally ill patient to access voluntary assisted dying if they so choose. The key word in the bill is, of course, “voluntary”—that is, for the patient and, importantly, for health practitioners. Furthermore, in order to be eligible to access voluntary assisted dying, the person must be at least 18 years of age, an Australian citizen or permanent resident and have been a resident of WA for at least 12 months. They must be

**Extract from *Hansard***

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diagnosed with a disease or illness that will lead to death within six months, or 12 months in the case of a neurodegenerative illness, and be deemed to be suffering such that they cannot be relieved to the extent that the patient finds tolerable. It is my firmest belief that it should not be up to another person what level of suffering is tolerable to another individual. In addition, for a patient to be eligible to access voluntary assisted dying, two independent doctors need to determine that the patient is making an enduring decision, so it must be verbal on two occasions and then written, so a decision cannot be made on a whim, and no coercion can be involved. Also, they need to assess the patient's decision-making capacity, which is, of course, critically important. There are 102 safeguard measures within the bill to ensure the protection of vulnerable and terminally ill patients and to provide a safe and transparent framework for end-of-life choices. This is an important point. We need to establish a legal framework for end-of-life choices. Currently, there is no real framework. This will invariably benefit patients and medical practitioners. There are very few means available for terminally ill patients, which is very traumatic for their end-of-life choices. Many choose palliative starvation and dehydration. This process of dying is terrible for the patient and their loved ones and can take up to two weeks.

As I mentioned, I have spoken with and heard from so many people in my electorate of Belmont, who have various opinions on whether the bill is the right thing to do. It has been really important and a great opportunity for me to listen to everybody's personal stories. I would like to express my thanks to everybody who contacted me and for sharing their stories with me because they are deeply personal and very difficult for them to share.

I recently held a voluntary assisted dying forum in my electorate with Hon Alannah MacTiernan, who spoke, along with the member for Morley. We were lucky enough to have Dr Grube with us. He has been working under a voluntary assisted dying framework in Oregon, which has been in place for 22 years. He was able to provide his insight and firsthand experience of operating within that framework for the full 22 years that it has been operating in Oregon. I was really pleased to see so many people come to that forum so they could not only hear about how this legislation will work, if it passes, but also hear firsthand from a doctor. Most importantly, they were able to come along and be involved in a forum where they could share their opinions and show respect, regardless of those opinions. It was fantastic to see so many people—120 people—come to that.

One elderly woman at the forum—I found this really confronting—grabbed me before the forum started because she wanted to share something with me that I have not come across before, but no doubt others have spoken about it. She desperately wanted autonomy over her final moments if she was unlucky enough to develop a terminal illness. She did not want to endure an agonising end to her life, which she witnessed so many of her friends and loved ones go through. She came up to me to say that she desperately hoped that this legislation would go through because she and her friends were sick of seeing one another stockpiling their prescription medication for use down the track should they need it if they were enduring a terminal illness. She shared a story with me. One of her very close friends was diagnosed with a terminal illness and was in immense pain. She tried to overdose on her thyroid medication. I have a thyroid issue and take thyroid medication daily. I can only imagine how much she would have had to consume. Sadly, it was not successful in her case. I say “sadly” because instead of dying, she is now rendered a vegetable, according to my constituent. This has created enormous fear for many of my constituents because, like their friend, they had been stockpiling medication. This is a really tragic scenario and outcome for not only the terminally ill woman, but also all her friends, family and loved ones who have had to watch her fade away as a vegetable, which were the words that she used. That is a really tragic outcome.

Another woman at the forum called me over. She was sitting up the front. She was struggling to breathe. She was very angry. She said, “Cassie, come over here. I'm furious. I am a practising Christian. I go to church every week and I do not understand why you or anybody else has a right to decide how and when I die.” She had a degenerative disease. She did not go into any detail about that disease, but she was outraged that a patient would not have the ultimate say about when it was their time to go and how much pain they should suffer. She said that regardless of people's religious views, she believed their religion should not impact on how they chose to die and whether they should access voluntary assisted dying. I fundamentally agree with that. Religious views do not belong in the examination room.

In July, Kerry Robertson became the first person to access voluntary assisted dying in Victoria since that legislation passed. She was only 61 but she had suffered from terminal cancer for years. In fact, she battled with cancer for nine years. Her two daughters, Jacqui and Nicole, told the advocacy group Go Gentle Australia that her death had been beautiful and peaceful. That is in stark contrast to other reports and research I have looked into relating to end-of-life scenarios involving people in palliative care and who are mostly experiencing pretty horrendous and painful deaths. They said of their mum, Kerry —

“Her body was failing her and she was in incredible pain. She'd been in pain for a long time.

“Palliative care did their job as well as they could. But it had been a long battle. She was tired, the pain was intolerable and there was no quality of life left for her.

**Extract from Hansard**

[ASSEMBLY — Thursday, 29 August 2019]

p6127c-6161a

Dr Tony Buti; Mr Chris Tallentire; Mr Mark Folkard; Ms Cassandra Rowe; Mr Yaz Mubarakai; Mr Ian Blayney; Dr Mike Nahan; Mr Simon Millman; Mr Dean Nalder; Ms Josie Farrer; Mr Sean L'Estrange; Mr Kevin Michel; Mr Bill Johnston; Ms Jessica Shaw; Mr Peter Tinley

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“We were there with her; her favourite music was playing in the background and she was surrounded by love. She left this world with courage and grace, knowing how much she is loved.”

This bill gives us the opportunity to recognise the importance of giving people a genuine choice and autonomy over their decision-making—allowing eligible people at the end of their life to access assisted dying. It will provide a safe and compassionate option for people with a terminal illness who will suffer, even in the best palliative care. Many have said that palliative care will be able to manage and treat pain, providing comfort for those at the end of their life, but unfortunately it has its limitations and it cannot relieve all suffering. Some suffering simply cannot be alleviated through palliative care. Palliative care, however, is a really important care option. Voluntary assisted dying is not a substitute for palliative care, nor is it an inevitable extension of palliative care. That is why our government will invest \$206 million in palliative care over the next four years.

Data shows us that about five per cent of people with a life-ending illness suffer irremediably, even in the best palliative care situations and settings. I would like to share with members Mr Bill Spanbroek’s comments to the Joint Select Committee on End of Life Choices about his experience with his stepson Michael Watkins, who was diagnosed, tragically, with juvenile Huntington’s disease. For the last year of Michael’s life, under the care of his parents at home, he had to be fed intravenously, having lost all ability to swallow, and he could barely walk. He had lost control of his bowels. Michael was eventually hospitalised after a brain haemorrhage. In his submission, Bill said —

We took him to the hospital where our neurologist was looking after him and he was given painkillers, morphine and what have you. We kept saying to the neurologist, “Peter, he is in pain.” He said, “But I have given him the limit of morphine; I cannot give him anymore”, and he said, “But he is not in pain.” Well, I can tell you the last thing he said. He lifted his head from the pillow and said, “Bullshit”. He was in hospital for five and a half weeks, and every night we drove home my wife and I said to each other, “He won’t be there tomorrow.” Five and a half weeks later, he passed away.

Belinda Teh, who was here earlier today, has publicly shared her grief at watching her mother’s excruciating final days battling terminal breast cancer, in the hope of raising awareness about voluntary assisted dying. Many of us have followed her walk across the country. When her mother, Mareia, was told that the chemotherapy treatment was hastening her death, she simply said to her oncologist, “Please help me go now.” As this was not currently an option, she was sent to a hospice to die. After three days in palliative care, she made the same request to doctors. Those final days sound nothing short of harrowing for both Mareia and her daughter. Belinda said in an interview —

“She was twitching and gasping for air, like someone was choking her,” ...

“My mother was totally unrecognisable. She stank. She looked awful and her skin was all these different colours—grey, purple, yellow and blue.”

Belinda also said in the same interview —

“As a result of the law, I watched my mum spent the last hours of her life in complete agony. The final four hours haunt me.”

One of my closest friends, Heather, had to watch her beautiful mum, Judy, suffer immeasurably in her final moments, after she lost her battle with terminal cancer in 2016. Heather shared with me the pain she endured witnessing her mother’s suffering. I quote —

Those last few days watching your loved one suffer, I wouldn’t wish it on my worst enemy.”

She also told me —

Some things you can never un-see and those last few hours of your mum or dad dying you will never forget.

[Member’s time extended.]

**Ms C.M. ROWE:** In an article by Andrew Denton, published by The Wheeler Centre, he tells of the experience of journalist Spencer Ratcliff who had to bear witness to the shocking suffering of his partner, Deb, while in palliative care. I quote the article —

Spencer, a journalist who had reported from war zones told me: ‘I’ve never see pain like it.’

He asked the nurse, ‘How can you sit and watch her in such pain and tell me she can’t have more morphine?’ ‘Because the doctor says I can’t’. The night palliative care team told him the same. ‘We’re not allowed to do any more.’

To whose benefit was Deb kept alive for a few more days of pain?

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A number of concerns have been raised with me about vulnerable people and how they could be coerced into ending their lives. I believe these have been fully addressed with strict eligibility criteria and strong safeguards to ensure they apply only to those for whom the law is written. These safeguards specifically include that the decision is well informed, that there is a requirement for more than one practitioner to be involved, that practitioners are appropriately trained to detect risk of coercion or abuse, and that there are multiple occasions in the process during which the person affirms their wishes. Twenty years of peer-reviewed evidence from North America shows that such safeguards work. They work because someone cannot be coerced into an advanced incurable illness that they do not have. It is even harder to coerce two doctors, whose work will be subject to review, to agree with them.

Former Perth radio veteran Howard Sattler, who is battling a degenerative brain disease, recently spoke out about wanting to end his life. He is quoted as saying —

“I just can’t go on much longer like this.

“I don’t want jump off a bridge or anything like that ... I just want to take a pill sometime, a nice gentle pill.”

Without voluntary assisted dying laws in place, many terminally ill people, or people with an incurable illness, who are experiencing immense suffering are attempting to end their life in violent and undignified ways. This can end in major physical and/or psychological damage to those people, if unsuccessful, as well as to their loved ones who must endure the trauma of losing someone to suicide. A person attending the planned suicide of a loved one may be charged with a criminal offence; therefore, the terminally ill person must end their life alone rather than with the support and love of the people around them.

Dr Grube was asked a confronting question by one of my constituents at my forum on voluntary assisted dying. He was asked, as a Christian and a doctor who worked in the voluntary assisted dying framework, whether he ever regretted any of his actions. His response floored us—he said yes; he regretted one case. One of his patients did not yet meet the eligibility criteria. He was terminally ill but did not yet meet the criteria. He regretted not being able to provide assistance. He did not specify what assistance; he just said he regretted not being able to provide assistance to this patient because the patient then took his own life. He hanged himself. Dr Grube said that the family never recovered from the grief of losing his patient to suicide.

In Western Australia, the parliamentary inquiry found that 10 per cent of all suicides were by people with terminal or debilitating chronic illnesses who saw no choice other than to take their own life; often, if not always, violently and alone. The most common method of suicide is hanging. Other methods include asphyxiation by plastic bag, or gunshot.

During the inquiry into voluntary assisted dying in Victoria, Coroner John Olle gave evidence of elderly, terminally ill people taking their lives. This makes for really harrowing reading, and no doubt harrowing deaths. He told of a 75-year-old man with prostate cancer who shot himself with a nail gun; a 93-year-old woman with agonising arthritis who bled to death after using razor blades; and an 85-year-old woman who did the same with the use of a number of knives and scissors. I feel sick even reading this out. This is not how anyone wants to die, and nor should they, if they are terminally ill and experiencing pain.

There needs to be compassion in our end-of-life choices. The Voluntary Assisted Dying Bill 2019 will alleviate the stress of people taking matters into their own hands and provide them with the freedom and autonomy to live the remainder of their life, and end it, with dignity and without enduring unbearable suffering.

Eight countries already have voluntary assisted dying laws, including Australia, with the state of Victoria making it legal in 2017. This state has had the opportunity to learn from those jurisdictions and the laws that they have in place. I believe the voluntary assisted dying laws that are proposed in Western Australia are among the safest and most conservative in the world. As has been the case with other members, my constituents are most upset that these laws do not go further.

I want to see this bill passed and voluntary assisted dying become enshrined in legislation so that terminally ill patients can die with dignity and be free from suffering. This is our opportunity to establish a transparent legal framework that has one objective for terminally ill patients who are suffering: compassion. This bill is long overdue and I desperately hope we are able to provide terminally ill patients who are enduring interminable suffering a choice about their own lives and the manner in which they end. This should be the most fundamental of rights.

I commend the bill to the house.

**MR Y. MUBARAKAI (Jandakot)** [4.10 pm]: It is not a choice in life to suffer from a chronic disease. Chronic diseases can strike down people at any age at any given moment, and they do not discriminate. Some diseases are quick to take over and can rapidly reduce people’s quality of life. They inevitably send them to a stage at which it is a struggle to live without pain—without hope and without dignity. This whole space has changed from 50 years

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ago when our grandparents and older members of our families simply passed away in their beds in their homes. Let us fast-forward to today when medical breakthroughs are giving the ill or dying longer in this world, but with zero quality of life, causing havoc, despair and heartache for all involved. The change represented by this Voluntary Assisted Dying Bill 2019 will allow medicine and law to catch up with dying in this modern day and also give the people who are in this space the decision to die with dignity. I am of the view that when people are incarcerated by chronic disease, when the illness takes away any hope of a future, and they are reliant upon palliative care and awaiting the inevitable, they deserve the right to choose, and I am fully supportive of the individual having that choice. What the Voluntary Assisted Dying Bill 2019 will do for those vulnerable people of Western Australia to whom it will directly apply is to give them the freedom to choose. This bill will require people to discuss their situation with trained health professionals and be made aware of alternatives, without the pressure of commitment, and with the opportunity to change their minds at any time. I refer to clause 18 of the bill, which is titled “No obligation to continue after making first request”. It has three subclauses. They state —

- (1) A person who makes a first request may decide at any time not to continue the request and assessment process.
- (2) The request and assessment process ends if the person decides not to continue the process.
- (3) If the request and assessment process ends under subsection (2), the person may begin a new request and assessment process by making a new first request.

Clause 26(1)(i) states —

that the patient may decide at any time not to continue the request and assessment process or not to access voluntary assisted dying;

Clause 52 again states —

**No obligation for patient to continue after completion of request and assessment process**

A patient in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

There is truly the opportunity and freedom for the person assessing this end-of-life choice to withdraw from his or her options.

Let me share the experience of a young family man, of a Western Australian family, with terminal tumours found in his stomach. He was told the news, along with his wife, on the night before their second son was born, that he had approximately six months to live. Words simply cannot describe the effect that this has had on them—a family’s life absolutely shattered by this discovery. He had terminal cancer; there was no way out of this. Acting on the medical specialist’s advice, they chose a pathway that saw him in the last few months of his life enduring this illness that was killing him and struggling to overcome the sickness from the medicine being used to prolong his life. He had no quality of life and no dignity. He was dying a very public, undignified and deeply sad death. He was losing control, and you could see the panic in his eyes. He did not want to go. So deeply embattled in trying to survive, he followed the advice of doctors who only had options that dealt with prolonging life, leading to his last five months on earth being spent fighting to live at the cost of being unable to function. He was not given a choice. In his dying days, when his mum arrived from Queensland to say goodbye, he was out of control in pain whilst his body was shutting down. His refusal to see his mum was a choice he made, and his mum was left distressed and so deeply wounded that her son was living his last days and that she could not get to him. But that was the only choice he had and it was not a choice he wanted to make. No-one wants their loved ones to live in memories of sadness; they want them to grieve in good memories. I would like this house to know that the man’s wife, Chev, requested I share her views first hand. To this day, and moving forward, she struggles with her loss and wishes that by members supporting this bill other families may not have to endure similar pain.

In Western Australia we have the fewest publicly funded palliative care inpatient beds per capita, with limitations to specialist palliative care across the state. This was the single largest issue addressed throughout the inquiry, and more work is needed to ensure that this sector stays up to speed with growing demand and expectations from our community. With an ever-growing and ageing population, a renewed focus on palliative care is important. The “WA End of Life and Palliative Care Strategy” outlines the government’s strategic statewide policy direction of the vision, values and priorities for improving the lives of all Western Australians through quality end-of-life and palliative care in Western Australia. Everyone should have access to timely, equitable, good-quality end-of-life care, with access to specialist palliative care whenever appropriate. Palliative care helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness, and I support the view that more needs to be done in this space to better cater for anyone in their days of ill health. Hon Roger Cook, MLA, Deputy Premier; Minister for Health; Mental Health, convened a palliative care summit on 17 August 2019 for

**Extract from Hansard**

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health practitioners, stakeholders and the community to explore ways to develop high-quality palliative care services for all Western Australians. I commend the minister for his efforts in addressing this issue front and centre.

In his speech, the Premier told the same story shared by our parliamentary colleague the member for South Perth, John McGrath, from election day 2017, of Clive Deverall. It cut deep. I know that me expressing Clive's wishes today is fitting to this bill. As members have already heard, Clive was the former head of the state's Cancer Council and its palliative care association, as well as being a Palliative Care Australia board member. Clive sent a message to Western Australia by ending his life this way, with a note that read, "Suicide is legal, euthanasia is not." Clive made a choice to end his life, staying in control and ending his suffering when his prognosis showed no hope, no cure and no chance of him beating his disease. According to national coronial data, around 10 per cent of suicides in Western Australia are by people with a terminal or debilitating illness. People who commit suicide due to a terminal illness die lonely and often violent deaths.

Planning ahead brings many benefits in day-to-day life, and when applied to the end-of-life choice it can help alleviate some of the distressing factors that hit hard when one's life is simply slipping away, such as the fear of dying. Planning end-of-life choices with trained health practitioners will assist individuals to cope with emotional, physical and mental trauma, and give them more time to make well-informed decisions and help them to get their affairs in order. The Voluntary Assisted Dying Bill will provide safe and compassionate access to voluntary assisted dying for eligible Western Australians with a terminal illness who would suffer, even with the best palliative care. It is an issue that has had ongoing support from the community for many years, and this legislation is based on compassionate grounds for people who are eligible to choose the timing and circumstances of their death.

I will tell members another personal experience of one of my constituents, Murray, and his wife, Sharon, who lost her battle with breast cancer three years ago. Murray contacted my office to share his story and his views on this bill and the need to get it through. The story that Murray shared with me about his wife, Sharon, struck a chord deep inside me, and it would be all too familiar to many other families in Western Australia. In 1996, Sharon was diagnosed with breast cancer. It was a shocking diagnosis for the family, but with no option but to push forward, Sharon pushed through the breast removal and the treatments to be given a clean bill of health, or so Sharon and Murray thought. Fifteen years later, in 2011, Sharon found another lump and upon getting it checked out by a doctor, they received the dire news that it was now stage 4 breast cancer. Again she pushed forward with the procedures and the chemotherapy, this time taking years, until the day came that her oncologist revealed that it was not working and that she needed to increase the dosage of chemotherapy.

I am saddened to say that that is when it all started to go downhill for Murray and Sharon, with Sharon's health diminishing with each treatment of chemo and the realisation by both Sharon and Murray that she was losing the battle against this aggressive cancer. The mental effect it had on them both was overwhelming and intense. Sharon was a proud woman and took great care with her appearance, but the effects of the treatment were prominent and Sharon's appearance was noticeably unhealthy. Her great will to live conflicted with the fact that she was dying. There was nothing that they could do except to live until that day came.

Murray reflected on the assisted dying bill, and said that if it had been legal then, a lot of pain and mental anguish could have been spared. Murray said that he and his wife discussed her end of life and they had both decided that at the end Murray would ask for the palliative care staff to assist in any way that they could to help end Sharon's life in a humane way—in a dignified way. Sharon and Murray's stepdaughters—one of whom lived overseas—returned home as often as they could. They started to prepare, but nothing could have prepared them for the turn that the end took. They did not see what was coming. No-one had told them that in palliative care, in the end stages of dying, their beloved wife and mother would become a mentally scared, sad and confused patient and start slipping away from life. She was unable to control any bodily functions. Being no longer able to swallow, she became dehydrated. Being unable to eat, her body began to starve and she eventually slipped into a coma. There was nothing for Sharon, and only pain for her family, who played a waiting game. They felt guilty when thoughts of hope that she would pass soon entered their heads, when they did not want her to go at all. Murray was sad that Sharon had no option or choice. She had to die like that. Murray would have liked for his wife to have had the control that this bill will allow.

The Voluntary Assisted Dying Bill is not an easy way out. It will allow people who are eligible to access this choice, based on 102 safeguards. For Western Australians, I am hopeful that this bill gets through because it will enable the people of Western Australia who still have decision-making capacity, and who have been diagnosed with a disease, illness or medical condition that meets a specific and limited set of criteria—those that will die within six months, or 12 months for neurodegenerative conditions—to make a choice. All eligibility criteria must be met. All process requirements must be met. Disability and mental illness alone do not satisfy the eligibility criteria. Assisted dying must be a choice made without coercion or force. It must be made voluntarily.

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These safeguards, as well as the palliative care services being expanded, will support a more humane, better informed end-of-life pathway for those who are at that stage, and will reduce the psychological and spiritual distress that we have heard spoken of by other members in this house today. There needs to be a choice. My friend needed this choice. Sharon and Murray needed this choice. The people of Western Australia want a choice. The Joint Select Committee on End of Life Choices heard from many people who would have loved for their loved ones to have had that choice.

[Member's time extended.]

**Mr Y. MUBARAKAI:** Clive Deverall highlighted the need for this choice by taking his own life and leaving a strong message with his dying note.

This Voluntary Assisted Dying Bill is a choice. It is my choice to speak so strongly for it. Finally, I will leave members with a quote from the final paragraph in the chair's foreword of the report into end-of-life choices—words by Mr James Hindle. He stated —

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

In the memory of Jonathan Ralph and Sharon Paddick, who would have wanted all Western Australians to have the freedom to choose and to not experience their pain and suffering in years to come, I fully support this bill and I respect the choice to choose.

**MR I.C. BLAYNEY (Geraldton)** [4.28 pm]: I rise to contribute to the second reading debate on the Voluntary Assisted Dying Bill 2019. Firstly, I commend the Joint Select Committee on End of Life Choices, which created the “My Life, My Choice” report. I read both reports and re-read sections of both extensively. It was one of the best committee reports that I have ever read. I commend the members, staff and witnesses for their work and their contribution. I found two sections particularly moving and disturbing. They were the transcript of evidence of Mr William Philip on page 45 and the transcript of evidence on page 127 from a witness who chose to withhold their identity. I want to thank those people for their evidence; it was because of those two pieces of evidence that I have resolved to support the legislation.

Geraldton is fortunate as a regional community because there is a palliative care facility at St John of God Geraldton Hospital, which I have only ever heard good things about. Likewise, we have three nursing homes, run by the Uniting Church, I think the Sisters of Nazareth, and the other facility is privately funded by Opal Aged Care. My mother was in one of them and, once again, they provided a very good level of care.

I would like to acknowledge the many people who have contacted my office on this issue. On an issue like this, a member is of course allowed to arrive at their own decision, in their own time, but I appreciate and respect all the communications that I have had on this issue. I acknowledge and respectfully thank a number of clergy who have spoken to me about this issue. In particular, I would like to thank Bishop Michael Morrissey of the Catholic Diocese of Geraldton and Bishop Gary Nelson of the Anglican Diocese of North West Australia. Both our bishops, as I call them, minister to vast areas of northern Western Australia, which is a hard task. They both stated their cases to me in a clear, firm and friendly way.

Likewise, I would like to acknowledge some other clergy who have spoken to me, and others who have offered to help me with these issues if I thought I was finding them a bit hard to understand: Pastor Jon Paschke of Lighthouse Uniting Church; Pastor Graham Fabian of Sun City Christian Centre; Gavin Hirschhausen of Strathalbyn Christian College; Kevin Merritt of the Geraldton Family Fellowship—80 per of whose congregation are Aboriginal people—and assistant Imam Daftie Kudus from Geraldton Mosque.

At a time like this, I think all members look back in particular to their childhood and formative years, and remember things said, generally in passing, by their parents. I think both my parents would have supported this bill. They were both strong country people who had a very strong Christian faith. They would not have seen supporting this bill as being un-Christian, although I do understand others who would see it that way; personally, I do not. Although this bill does not address this issue, when I was speaking about this bill with my sister recently, she recalled how disturbed my father was to see his mother spend seven years in a nursing home, for the last four of which she was a virtual vegetable, with dementia. As others have noted here, this bill does not go near this issue. Many people will be unhappy with that, but I understand the different legal complexities of that issue.

I would like to reinforce the concerns of the member for Warren–Blackwood: without something like voluntary assisted dying legislation, the acceptance of the use of firearms to dispatch livestock when there is no other help possible for them—which I personally have had to do fairly often—means that the incidence of suicides in the bush will continue. Of course, if it is not by firearms, it will be by vehicles or by drinking toxic chemicals. I am sure most country members will be aware of cases like these.

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The other deciding factor for me in supporting this legislation was the passing of my father-in-law, Pell House, of Kojonup. Pell had inherited a family condition called polycystic kidney disease. My mother-in-law drove him three times a week from Kojonup to Albany, which is 170 kilometres each way, so he could have dialysis. When my mother-in-law reached the age of 80, they decided to move to Albany to live. In his eighty-seventh year, Pell fell and broke his hip. Life was already becoming hard, with a lot of pain from his knees; he had had a lifetime of hard physical labour, clearing and developing his farm. Pell decided to refuse to have any more dialysis. The family respected his decision. The doctor said that he would gradually fade away, and simply go to sleep—somewhere between three and seven days. As it was, he lasted for about five days. Nobody suggested that we should pin Pell down and insist that he have dialysis. Frankly, I do not see any difference between his decision to stop dialysis and fade away and a request by somebody who has a clear cancer prognosis, for example, and an unpleasant end coming, to take a simple mixture and have a pain-free end, surrounded by their family, as I am told people can do in other places.

I am not what you would call a very strong libertarian. For the good of the community, I accept that government sometimes has to tell people what to do. But I do see this as a simple right, and I do not think anybody has the right to tell people that they cannot have access to this if it is what they want. It is probably what I would want. Personally, if I were in the early stages of dementia, I would want it in that case as well, but that is something for another day and for another time, maybe. If others do not want to use it, I respect their right not to. But please accept that it might be my wish, and I think that I should have the right to take that path if that is my wish. It is not a sophisticated argument. I admit that I come from a straightforward family and I had parents whose strong, simple faith I have inherited.

I conclude my remarks with a quote from Ecclesiasticus 30:17 —

Death is better than a miserable life, and eternal rest than chronic illness.

It is how it is brought about, I guess.

With that, I commend the bill to the house.

**DR M.D. NAHAN (Riverton)** [4.35 pm]: I could say that it is a pleasure to speak on this bill, but this is a difficult one. It is difficult for all of us. First of all, I would like to congratulate the government on bringing forward this debate on end-of-life choices and, specifically, this bill. It is a bill that the public wants and is demanding and, quite frankly, a bill that we need to debate. I would also like to thank the government for bringing forward a wider debate on end-of-life choices. Unfortunately, even we baby boomers will die some day. We might not like it, but it is coming more quickly than we might think. It is something that we do not like to think about, but we need to, and we need to plan for it, and the government has planned a wider debate on that, so I thank it for that.

I would like to also thank all members here for a very constructive debate and the various people who made submissions—the proponents, the opponents, the experts and all. It has been a painful, not enjoyable, but necessary process. I would like to thank the many hundreds of people who have responded to the request from my electorate office to give me their views, and many have been forthcoming. I also made some efforts, as did the member for Vasse, to talk to the people who are at the pointy end of these issues—that is, older people—and I will talk a little about their views.

This is not meant to be the point of this debate, but I would like to thank the Australian Medical Association and Hon Nick Goiran for their contributions to this debate. I do not necessarily share their views, but they have made important contributions. Let us be honest: this bill is, in all but name, a government bill. The Labor Party has a structure under which it does not allow public dissent on collective decisions. Obviously, people in the Labor Party have different views, and it is therefore a government decision. The Premier made it clear in 2017 that he wanted to bring in a bill in 18 months' time—that is now—that would allow assisted dying. It was all pre-determined. He appointed a parliamentary secretary to produce it, and they have done so.

This is a bill that was always going to go down a certain path. The government allowed all people to participate, but the debate was skewed in one direction, which is probably a necessity to get things done in this Parliament. But one of the important things that I have learnt in this place is that it is often the opponents who add the most value to a bill and to a set of actions. The AMA's view surprised me, to some extent, but it was really constructive, and I have a lot of respect for it and for Hon Nick Goiran. I do not necessarily share Hon Nick Goiran's conclusions, but his arguments for improving this bill have been profound.

Clearly, this is a popular issue. It is not the 88 per cent support that *The West Australian* came up with, but who believes polls in *The West*? It is overwhelmingly popular. My point is that people not only want this bill, but they want to go way beyond where this bill goes, and where I would accept it to go. I do not think this is the end point of this debate. As the member for Geraldton indicated, a large number of people would want voluntary assisted dying to come into play if they have dementia, or just to pre-empt what is to come. That is not what this bill will do, and I would not support that. However, if the public wants to go there, that is a debate we will need to have.

**Extract from Hansard**

[ASSEMBLY — Thursday, 29 August 2019]

p6127c-6161a

Dr Tony Buti; Mr Chris Tallentire; Mr Mark Folkard; Ms Cassandra Rowe; Mr Yaz Mubarakai; Mr Ian Blayney; Dr Mike Nahan; Mr Simon Millman; Mr Dean Nalder; Ms Josie Farrer; Mr Sean L'Estrange; Mr Kevin Michel; Mr Bill Johnston; Ms Jessica Shaw; Mr Peter Tinley

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That is why, when we face difficult issues such as this, we in this Parliament have to make judgements on behalf of our constituents, and that is what we are doing today.

I congratulate Liberal Party members for their actions and behaviour in this debate. When I was Leader of the Liberal Party, there was a rumour, in the media in particular, that the Liberal Party would be taking a stand against the euthanasia debate. That was never the case. I indicated from the start, as the then Leader of the Liberal Party, that I welcomed the debate, and the process, and I still do. I also indicated from the start that Liberal Party members would be given a conscience vote, and they will. We have never contemplated changing that. Some members of the Liberal Party support this legislation, and some are against it. Some would like more evidence. There is a wide range of views. The Liberal Party participated in the joint select committee process on this bill. Hon Nick Goiran was against it. John McGrath, the member for South Perth, did not want to go on that committee, but I shoehorned him into it. He is a big man—it is difficult to shoehorn him into anything! He went into the committee with an open mind, and he came out in support of the legislation. That is a constructive contribution to a difficult debate.

I have received a lot of aggressive emails and correspondence about this bill. I can take that. Like many members in this Parliament, I have experienced a lot of this stuff firsthand. I am not saying I am an expert on it. I am not saying my experiences are emblematic of the general situation. However, I have a story that is interesting. My mother had breast cancer, and over a 10-year period, it metastasised, and she died. She lived in Oregon in the United States of America, which has assisted dying legislation. She fitted the legislation that applied in Oregon. My brother, who lived in Vancouver, Canada, which has a similar program, contracted Parkinson's disease at a young age, and died 15 years later. He also fitted the legislation that applied in British Columbia. I will come back to that.

I have to say that I am concerned about some of the language that is used in this debate. We are dealing with a very important issue, and we need to use the right words. This is a program of voluntary assisted suicide, or euthanasia. I will not dwell on that, because other people have debated it, but that is what it is. By the way, if the safeguards are strong enough, I will support the bill. However, too many times in life we use politically correct language to hide from the real issues. That is why more restrictions are in place in this legislation than the public really wants. The member for Girrawheen quoted Paul Keating from an article in *The Sydney Morning Herald*. I do not often agree with Paul Keating. However, on this occasion, he is right, although I do not come to the same conclusion. We are crossing the Rubicon. We are crossing the boundary of where our definition of civilised society has not gone up until now—that is, allowing the state to sponsor voluntary assisted suicide, or euthanasia. We are. This is an important issue. It is premature death. That does not mean you do not cross that line, but you cross it with your eyes wide open, knowing that there is no going back. That is why it is vitally important that the appropriate safeguards are put in place. Paul Keating said also that this is the pursuit of a utopian game or process, and that we cannot put in place adequate safeguards to ensure that people are not coerced to take this course of action, and, more importantly, that people do not use it prematurely. It is a slippery slope. That is a very big ask. However, we need to try. All sorts of social activity—welfare and others—are utopian to some extent, but we have to try.

People have said to me that my Catholic upbringing will push me along the route of caution, and it has. However, I am also a libertarian, so I am kind of confused here. Nonetheless, if the target group is restricted to people who have a terminal illness and death is imminent, and for whom palliative care has been tried and failed, but who are still able to make a conscious decision, and do so voluntarily, I support the bill. However, I have a number of concerns. I am concerned and dismayed about the availability of palliative care. As the Australian Medical Association has said, quite rightly, we are proposing to give doctors another option for people who are facing a painful death. We are giving doctors, and patients, of course, the alternative of voluntary assisted suicide, or euthanasia. That is what we are doing. Again, I call it what it is. Palliative care must have been tried and failed. All the evidence I have seen put forward—I may not have the best evidence; I do not know—is that we underspend on palliative care, not just in regional and rural areas, although clearly there we do, but overall. I am surprised that the government did not enter into a parallel process of examining voluntary assisted dying at the same time as it examined not just the level of funding, but also the delivery of palliative care services in the metropolitan region and in regional and remote areas. If those two processes were progressed at the same time, we would have been able to have had, not a cognate debate as such, but an understanding of the enhancements in palliative care before we had to make a decision about voluntary assisted dying. One thing is true: if people do not have adequate palliative care services, but they have voluntary assisted dying, they do not have many options. Therefore, I am surprised the government did not pursue these two things in parallel. That creates a problem for me in supporting the bill, and I am not sure how I will work through that.

In the government's last budget, it allocated approximately \$41 million for palliative care. I understand that \$10 million of that amount will not go to palliative care at all. However, I welcome the funding for palliative care services in regional and remote areas. It is not just about money. As the member for Warren–Blackwood said, we will never have enough money to meet the demand for palliative care services. I do not live in utopia, and I do not

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have utopian beliefs. However, the evidence is that Western Australia spends less on palliative care than the other states do. We should address that at the same time as we progress this bill. The two are not independent.

I want to go back to the situation with my mother. My mother, who lived in Oregon, did not need to access voluntary assisted dying. That is because she had excellent palliative care. She was blessed—she had two daughters who were palliative care nurses, and a son-in-law who had been a palliative care doctor. Palliative care can do a lot to avoid the need for voluntary assisted dying. That is the message. Another issue from the expert in Canada—my brother also went through this—is that when someone is given a death sentence, as my brother was with Parkinson's disease, it is traumatic, especially at a young age. It traumatises the patient, their loved ones and friends. They know where they are going with this disease. They do not know how quickly, but they often think the worst and want to pre-empt it. We are a society of people who like to take control of our domain. We like to take control of our lives, live our life the way we want and die the way we want, and we act in a pre-emptive manner. All sorts of psychological factors are at work. Everyone knows the physical attributes of Parkinson's disease, but the worst ones are mental; they are profound. My brother was a senior mining executive, and he had to quit his job because he could not take the stress. He could not sleep. Luckily, he was wealthy enough to see a psychiatrist and deal with the trauma of facing the finality of life. It was a blessing. He contracted the disease early. Most of the data on prognosis was based on people 20 years older than him, and I do not know how it fitted. From memory, the prognosis was something like one to six years, but he lived 15 years. The disease progressed more slowly than is the case for older people, but, more importantly, the medicine improved significantly. If he had acted pre-emptively, he would have ended his life early and done away with some of the best parts of his life. Yes, there were some negative attributes, but he lived 15 more years with his wife and children.

That is the pain of this discussion. I understand that in Canada, 60 per cent of people who apply for voluntary assisted dying are suffering from existential trauma—the news that they are going to die within a certain period and that it is likely to be painful. I might add that this is prior to the palliative care not working. How do we deal with this? We would have to deal with this through widespread psychiatric treatment of people who have received the news. We all have experience of people getting the dreaded news and looking at where they are going in life. We need assistance on that, particularly with the pressure from the community to widen this debate significantly. We need greater resources for screening to address the existential trauma of people trying to pre-empt bad news. Submissions from the psychiatric community made this clear to the committee, and I think it needs to act on it.

[Member's time extended.]

**Dr M.D. NAHAN:** One of the issues that I am surprised about, particularly coming from the Labor Party, is coercion. Ninety-five per cent of the people who get into the situation in which they have a loved one on a pathway to a painful death, when palliative care is not working, would hold back, reluctantly. Certainly, that is my experience. For most of us, it is just unheard of that family members, doctors or anybody else would try to coerce people into a premature death, but I assure members that it is there. Go through the elder abuse issues. As a local member of Parliament, I am shocked by what some kids do to their parents and its subterranean psychological impact. I know that a range of processes are underway to prevent or mitigate the problem, but, on the basis of overseas data, dismissing it is wrong. We have to do more to identify, pre-emptively, the risk of coercion. We will discuss that in consideration in detail. We have general practitioners, but as has been the case overseas, specialist doctors providing this service will spring up. I am not criticising the specialists in this area. A lot of people do not have a GP who sees them regularly. A lot of people, especially those on low incomes, go to bulk-billing clinics and see the doctor on duty, and the doctor does not know the patient except from the data. Some people will be professional witnesses—witnessing, quite rightly, what the patient says—but we have to go beyond that. I am surprised that there has not been more concern about coercion in the various debates to date, because I think it will be a real issue. As with suicide, after it happens it is too late. There could be all sorts of issues with disabled or elderly people, dysfunctional families, or the Aboriginal community. We have heard all these issues. More effort must be put in to address, root out and identify coercion. Even if there were coercion, it does not mean that a person would change their decision, but—this is the issue of crossing the Rubicon—we are dealing with death, and one premature death is one too many.

I stand ready to support this bill on certain conditions. I expect to see from the government not just more resources, but a clear strategy to address the investment in and access to palliative care. I am not making a political point here. I guess I am a politician, but this is what has been highlighted vigorously by the experts. Secondly, we need clear access to psychiatric screening for both the existential stress or trauma and the pressure that gives rise to someone ending their life prematurely. The issue of coercion is fundamental and needs to be addressed. We have to look at that in consideration in detail.

To go back to the issue, the process that we have gone through has been traumatic but important. There has been a lot of argy-bargy in the debate about how the Liberal Party would approach this issue, but most of it was wrong.

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I praise Hon Nick Goiran for his contribution. He probably disagrees with my decisions and statements, but he has made a profound contribution to this bill and this argument. His arguments were very forceful and in support of the Australian Medical Association. Most importantly, I look forward to consideration in detail, when the government explains and discusses palliative care, coercion, and enhancement of expenditure on psychiatric treatment, and also goes out into my community to discuss in great detail why this bill is rightly more restrictive—although not enough, in my view—than what most people in the community expect and want. In other words, we have another stage of debate to go through on this issue. Yes, it is popular, and popular is important, and we as politicians have to respond to that, but it is also important to know that we as politicians need to guide and discuss with our constituents the problems of going where they want us to go on this issue. Thank you very much.

**MR S.A. MILLMAN (Mount Lawley)** [5.58 pm]: I rise to make a short contribution to the debate on the Voluntary Assisted Dying Bill 2019, and I state at the outset that I will be voting in support of this legislation. What I have seen over the last two days would have to go down as Parliament at its absolute finest. People have come here with reasoned and considered debate, and they have delivered it with passion and conviction. They have clearly and unambiguously articulated their positions, and approached it thoughtfully. I have seen this Parliament play host to many guests in the gallery who have listened to the debate with keen interest—advocates for and against the proposal that has been brought forward for debate. I heard the former Leader of the Opposition congratulate the government in the most magnanimous way for bringing forward this bill.

When I participated on the Joint Select Committee on End of Life Choices, at the tabling of the report I said that when this matter comes on for debate in this house, as it surely will, I urge members to consult their constituents, to hear their views and input into this debate. This is a very difficult and complicated debate and we can serve our communities and the state of Western Australia by listening attentively to what our constituents have to say. Once the Premier sat down, the member for Dawesville, the shadow Minister for Health, stood and told us in clear and unambiguous terms precisely how he had gone about the task of identifying the views of his constituents. In exactly the same way, the member for Perth, thoroughly and with great diligence, listened to his community. We can see that many of us have dealt with the sacred burden we bear—the sacred responsibility we hold—in representing our communities by going out there and listening to what they say. I am very impressed by that. As members know, this is a conscience vote. A conscience vote is a vote of your personal conscience. What do your values and beliefs tell you? Each of us could have been excused for coming here and saying, “This is what my conscience says I should do about this legislation.” But none of us has. Each of us has gone out to try to discern the collective conscience of our communities so that that also can be represented. Although there may be disagreements on what that may look like—I listened with great interest to all those debates—people have come to this debate with conscience.

Many people have spoken about their religious convictions, and as a member of the Anglican Church, I respect that. As a representative of a community of many Greek Orthodox, Roman Catholic and Jewish people, I can see that religion plays an important part in this debate. I do not propose to talk about the religious convictions of the opponents of VAD, but I understand them. In particular, I would like to thank some of my friends, such as Peter, Tim and Eric for discussing the issue with me at length. The evidence of Rabbi Dovid Freilich before the Joint Select Committee on End of Life Choices was particularly compelling.

I also listened with keen interest to the contributions to this debate of people of faith, such as the member for Girrawheen, the member for Southern River, the member for Kalamunda, the member for Geraldton, who just now told us he also consulted religious leaders in his community, and the incredible speech delivered by the Attorney General this morning when he spoke about the role of faith and religion in how he came to make his decision.

I want to talk about the leadership that has been provided in this debate. Many members have thanked the Joint Select Committee on End of Life Choices for all the work it did in the preparation of this legislation. The members of that committee—I count myself amongst them—have done an incredible job in demonstrating the necessary leadership for this debate. As the member for Riverton just said, Hon Nick Goiran represented the contrary position. However, I listened to the contributions from the member for South Perth and the member for Baldivis. I recall the discussions and debates we had with Hon Dr Sally Talbot, Hon Robin Chapple and Hon Colin Holt, the deputy chair of the committee. I know that great leadership in this debate has been provided by my fellow members of the Joint Select Committee on End of Life Choices. It was great to listen to the contribution from the member for Morley as she thanked the Premier, the Minister for Health and the Attorney General for their leadership in this debate. In no uncertain terms, I add to that list the member for Morley, who, both through the chairing of the Joint Select Committee on End of Life Choices and all her conduct thereafter, has shown tremendous leadership and great fortitude in prosecuting the case for this modern VAD legislation.

In arriving at my decision to support this legislation, I have been very fortunate. I was honoured to participate in the joint select committee and I was especially grateful to be asked by the Attorney General, together with the Minister

**Extract from Hansard**

[ASSEMBLY — Thursday, 29 August 2019]

p6127c-6161a

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for Health, to chair the Ministerial Expert Panel on Advance Health Directives. It gave me a rare opportunity to look into my own conscience and determine what issues would be most pertinent, most important and most relevant to the way I went about deciding which way I would vote. Like you, Deputy Speaker, and the Treasurer, this was not a foregone conclusion. I have always wrestled with this because it is such an interesting philosophical question. When members see how this debate has evolved and the outstanding work Malcolm McCusker, AC, QC, did as chair of the other ministerial expert panel, and the thoughtfulness of the contributions made, the safeguards that have been incorporated into this legislation and how conservative and sensible this legislation is, we can see that it is the appropriate legislation for a modern Western Australia.

I was fortunate to have had access to all that information, all that evidence and all the compelling stories we heard as we sat in those committee hearings. However, I have been fortified in my view that I should support this legislation by some of the incredible contributions made by members in this chamber. I do not have the personal stories to tell. Thank God, my mum and dad are both still alive and my family are all well—touch wood. I do not have those stories. My constituents have shared their stories with me. They are personal, private stories, so I do not propose to share their stories, but I am fortified because I have heard many incredible stories from the compassionate people in this chamber who have gone out and shown empathy in listening to their constituents and conveying those messages so that we can deliberate properly on this legislation.

I want to make one point on the question of capacity, if I may, because this is something that has come up in debate and a point that people have expressed some reservation about. Can I say this: we are right to identify that capacity is an important consideration, but I would like to put forward a number of arguments to suggest that this legislation is well crafted and has the appropriate safeguards to make sure that we need not maintain those concerns about capacity. I would like to refer to a couple of things. Members will have had the opportunity, I am sure, to review the report of the Joint Select Committee into End of Life Choices. Chapter 4 of the majority report deals with current lawful options at the end of life. Chapter 4 of that report confirms that refusal of medical treatment is not suicide, and confirms that a competent individual could refuse medical treatment and refuse food and fluids. I refer members to the paragraph under the heading “Refusal of medical treatment” that states —

Patients can, and do, choose to refuse medical treatment—including refusals that may result in death.

We are talking here about a medical intervention, or non-intervention, that may result in death —

Patient autonomy—the right to choose health care—emerged as a dominant medical ethical principle during the twentieth century and is usually associated with allowing patients to make their own health care decisions. The ethical principle of autonomy is contained in some form in most modern medical codes of conduct in the Western world.

The refusal of medical treatment, as it exists under the law of Western Australia, does not require a capacity assessment by a psychiatrist.

Can I talk about the refusal of food and fluids. The report states —

A competent individual can lawfully end their life by opting to stop eating and drinking. In accordance with the ethical principle of patient autonomy, and the legal principle of self-determination, the common law recognises the right of a competent adult to refuse food and water.

This is from the journal article of White, Willmott and Savulescu, which I think the member for Armadale quoted in his contribution earlier.

I refer to the evidence of Professor Max Kamien, a very prominent practitioner, particularly within the Jewish community. He told the committee about a friend who had deliberately starved himself to death. I will quote his evidence, in the time that I have —

He developed an oesophageal pouch—that is a pouch on the oesophagus—and food gets caught in it. You have terribly bad breath. It is very difficult to swallow. The operation is very difficult. It nearly always cuts the recurrent laryngeal nerve which is the nerve that goes to the voice box. If he had that operation, he would never sing again. The other thing is the operation has a mortality rate in itself which is, depending on who does it, quite high. He said, “If I can’t sing, I can’t speak properly, and if there is the possibility that something goes wrong and I finish up a vegetable ... I will not have that operation” and he ceased food for four months and he starved to death.

My point is that no psychiatric capacity assessment is required for people to exercise these existing lawful options at the end of life, the refusal of medical treatment and the refusal of hydration and nutrition. Hence, finding 25 of the joint select committee states —

A competent person’s absolute right to refuse to eat and drink is clear at law ...

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We need to proceed by analogy. That is the current state of the law with respect to capacity assessments.

I take members to chapter 2 of the report, “Advance Health Care Planning”. I know quite a bit about this, having finished my work as the chair of the Ministerial Expert Panel on Advance Health Directives. Rather than summarise it, I will quote chapter 2 of the joint select committee’s report —

Many people worry about losing the ability to make their health care preferences known in the event that they lose decision-making capacity. People also commonly worry about being kept alive in unacceptable circumstances with greatly diminished ability to advocate for their preferred care—for example, with dementia or in a persistent vegetative state following traumatic or non-traumatic brain injury.

...

In Western Australia when a person is unable to make reasonable judgments —

That is, when a person lacks capacity —

in respect of any proposed medical treatment, and there is a need for a treatment decision, the *Guardianship and Administration Act* ... determines which treatment decision will be given precedence.

If members look over the page, they will see the way in which capacity is already assessed in accordance with the legal provisions in Western Australia. There is a presumption under Australian law that every adult person has capacity. It states —

Generally, when a person has capacity they can

- understand the facts and choices involved;
- weigh up the options and the consequences; and
- communicate the decision.

In everyday life, people who have capacity make decisions about where to live, what to buy, how and when to travel, when to see the doctor, and numerous other daily decisions that ordinarily enable them to live independently.

**Capacity is decision specific and is about the decision-making process**

If members are concerned about capacity, they can see that it was the focus of a great deal of attention during the deliberations of the joint select committee. We were particularly concerned about this. Other members have expressed their thoughts about whether the legislation goes far enough for people with dementia. The government’s position on that is abundantly clear and does not need to be repeated. We considered the current law on refusing medical treatment or refusing hydration and nutrition and then looked at how capacity is assessed under the *Guardianship and Administration Act 1990*. Chapter 7 of the report of the Joint Select Committee on End of Life Choices set out the essential elements that would be necessary to ensure that this legislation was properly safeguarded. It considers things such as the expected time of death. A narrowly defined sample set of people would be able to access this. We set out the level of suffering experienced and the age of the person. Paragraph 7.49, “Capacity and capacity assessment”, states —

An individual must have decision-making capacity ...

That is unambiguous and unequivocal —

at the time of their request in order to be eligible for voluntary assisted dying.

Paragraph 7.50 states —

Although capacity assessments can be complex, General Practitioners routinely assess capacity ...

To come to this conclusion, we relied on the evidence of none other than the Royal Australian College of General Practitioners. It continues —

- patients making decisions about consenting to or refusing medical treatment;
- individuals making legally binding instruments (such as enduring powers of guardianship, enduring powers of attorney and Wills);
- the State Administrative Tribunal ...
- referral under the *Mental Health Act* ...

The committee received evidence from the Chief Psychiatrist about decision-making capacity. But more relevantly and more persuasively, we received evidence from Dr Roger Paterson, a psychiatrist, who told us that the view of the Chief Psychiatrist was not in keeping with the consensus in other jurisdictions that general practitioners should—not would or could; that is, it contains a moral imperative—ordinarily make the assessment. Quoting from his evidence, he said —

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He is out of step with every jurisdiction internationally and nationally. The Victorian legislation does not propose it. He is out of step with the Royal Australian and New Zealand College of Psychiatrists who say it should be considered, and he is out of step with the local branch who, as I say, recognise that there are practical logistical problems as to why it is not so.

We also ascertained —

A requirement that there be a referral for specialist psychiatric capacity assessment is likely to involve considerable delay ...

We should bear in mind that this legislation provides for people who have a prognosis of six months left to live. The very last thing that these people should have to do is wait and wait and wait while they get a psychiatric capacity assessment when their general practitioner can already make that assessment and when, under the existing law of Western Australia on refusing medical treatment or refusing hydration or nutrition, that capacity assessment is not required. We concluded with finding 51 —

An individual must have decision-making capacity at the time of their request in order to be eligible for voluntary assisted dying.

[Member's time extended.]

**Mr S.A. MILLMAN:** The capacity assessment is routinely made in current circumstances. Those members who are concerned about the provision on capacity assessment contained in this legislation need not be. People can be comforted that this legislation deals with the question of capacity in the most appropriate way. That is my submission.

I want to conclude with my thankyou's. I wish to thank a number of people. I will miss people and, to those people, I am sorry. I thank Nigel Haines. He was mentioned by the Minister for Culture and the Arts, the member for Mandurah. Nigel is a constituent of his. Nigel Haines not only bravely came before the Joint Select Committee on End of Life Choices to give his evidence about the circumstances surrounding the death of his wife Susie, but also then, despite how significant and burdensome the emotional weight was for him, nonetheless participated as the community member on the advance health directives panel.

I thank Max Kamien and all the people in the public gallery, who have sat here and listened to this debate—many advocates for and against. I thank all members who have already contributed. I thank witnesses who gave evidence to the committee—again, some in favour of and some opposed to the introduction of the legislation. All members have already commended the Minister for Health for the excellent work that he has done, along with the Attorney General and the Premier. Many members have already thanked the ministerial expert panel and Malcolm McCusker for the work that they have done. I thank all the members of the AHD panel and all members of the joint select committee.

I finish by individually thanking members of the joint select committee, including Hon Nick Goiran, who, as the member for Riverton said, was the voice of the opposing argument. The community appears to be significantly in favour of this legislation, with a minority opposed. The speakers in this Parliament appear to be significantly in favour of this legislation, with a minority opposed. The Joint Select Committee on End of Life Choices was significantly in favour of this legislation, with a minority opposed—Hon Nick Goiran. It is relatively reflective of the state of people's opinions. I thank Hon Robin Chapple, Hon Dr Sally Talbot, and Hon Colin Holt, who did an excellent job as the deputy chair of the committee. I thank the member for Baldy and the member for South Perth, and, finally, like so many others, I express my thanks to the member for Morley.

Let me finish by making two points; one of them has already been made by the Premier in his contribution to the second reading. I quote from the copious notes I made yesterday. The Premier said —

For those in this chamber who approach politics through the paradigm of freedom and rights ... is this not an incredibly simple issue to decide? This is the ultimate act of personal choice, of freedom, of individual rights.

I agree with that sentiment. I guess in one way people could say I am a John Stuart Mill-man!

**Mr Z.R.F. Kirkup** interjected.

**Mr S.A. MILLMAN:** Thank you.

The second thing I would say is that our Constitution requires us to make laws with respect to peace, order and good government. The point at which I finally decided to support this legislation was when one of the witnesses who appeared before the committee said, "If you pass this bill, such a small proportion of the population will think about it, and an even smaller proportion of the population will use it, but everyone who is worried about it will have peace of mind." When our Constitution enjoins us to make laws with respect to peace, order and good government, it also means peace of mind. When I heard the earlier contribution that there would be nothing

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quite like leaving your children to remember a painful, prolonged, nasty death for the rest of their lives, I thought: what great peace of mind I would have, were this legislation to pass, to know that I would never impose that burden on my two sons.

I have been incredibly impressed with all the contributions that have been made by members in this chamber. I am incredibly honoured to have been part of this historic debate. I commend the bill to the house.

**MR D.C. NALDER (Bateman)** [5.21 pm]: I, too, stand to make a contribution on the bill before the house, the Voluntary Assisted Dying Bill 2019. I say at the outset that I am quite envious of those members in this chamber who have a solid position, whether it be for or against. I have heard arguments on both sides of the debate that I agree with. I am envious because I am sure that most people have had far better sleep than I have in considering this issue over the last few months. I will ultimately reserve my judgement until the consideration in detail stage because I believe that some concerns need to be worked through, as many speakers before me have mentioned.

This bill really challenges my beliefs and values. When I talk about that, I strongly believe in the freedom of choice, but I also strongly believe in the sanctity and preservation of life. I find myself conflicted on both of those issues in consideration of this bill.

I would also like to acknowledge, similar to the member for Mount Lawley, that all the members of this place are acting with compassion. Compassion is at the front and centre of members' minds. I believe that no-one in this day and age should suffer in agony. I believe that it is incumbent on us to ensure that laws and protections are in place for people who are dealing with end-of-life issues and that they can do so with dignity and respect and in the most comfort that can be provided.

I would like to acknowledge some comments made earlier by the Minister for Health in his second reading speech that resonated with me. The minister said that decisions are already being made about ending life when life support systems are turned off or when it is decided to cease fluids or food. We know that the outcome will be death. We are making decisions about someone's life today, and why would we not extend it further for those people who are desperately in need?

I have great respect for Malcolm McCusker. I was really pleased to see his involvement in the drafting of the bill. He should be acknowledged for his standing in our community; he is someone who is respected by all.

I would also like to acknowledge that palliative care does not provide for all people in the manner we would hope. That is an issue that confronts us today. I see that as the primary purpose of this bill. In saying that, I will now step through my concerns and demonstrate that there is a balance to this argument that I have given consideration to. Describing it in simplistic terms, my primary issue is that it feels as though we have jumped to the endgame. For me, the issue of palliative care needs to be resolved either in conjunction with or prior to us getting to that point. That is a stumbling block that I have and that is why I will defer my decision until the consideration in detail stage.

I believe that as parliamentarians we should be ensuring that we deliver world's best palliative care. We live in one of the best places in the world. We have some of the highest living standards in the world. It is incumbent on us to ensure that we deliver the best possible palliative care. I know there are regional challenges and so forth, but if we are not delivering on that, I fear that we are not giving people a choice when it comes to voluntary assisted dying. Some people will see it that they have no choice. That really concerns me; it is a fear that I hold. Although I acknowledge that there are people we are desperately trying to help, I am also fearful that we may create an outcome that forces people down a certain path. I have an inkling of concern—not the same level of concern—about people acting with compassion, although I acknowledge that everybody in this chamber has spoken responsibly and ethically about this bill and has acted with concern and compassion for patients who are suffering from a terminal illness. When it comes to my experiences in life, I do not believe that all people act with compassion. I have seen people act with very little compassion. Sometimes it might be in their minds that they are acting with compassion. They may believe they are acting in the best interests of someone when in fact they are not. I will stretch that a little further and say that when it comes to money, people act with even less compassion. I am fearful that if we do not address palliative care in its complete form, it could become an economic decision that people ultimately choose to end their life. We are going to be relying on future generations to assess this: if we do not address palliative care, what choice are we giving people? I fear, albeit a lesser fear, that in the future people might see it as more convenient for people to end their life rather than follow the costly process of palliative care. I would hate for our community to ever walk down that path. It is a concern that I have within my community.

A number of concerns were raised by other members in this place. I concur with a lot of those concerns. I wrote them down to go through them, but I would just be repeating them and I will not be repetitive.

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I would like to acknowledge the Leader of the Opposition. She raised a number of pertinent points that warrant further investigation through the consideration in detail stage of this bill. I felt the Leader of the Opposition's speech was very powerful in sharing with us the challenges that she has faced with this particular issue. I personally have had experience. I do not wish to elaborate on it further but I understand the issues that people go through.

I have other issues with this bill that I am concerned about, and they are about the safeguards to be put in place. I know a number of measures have been put up. I have to admit that I am not an expert on those measures and therefore look forward to exploring them fully in the consideration in detail stage. That is part of the reason I will defer my judgement on this bill until we go through it adequately.

I would also like to share that I, too, polled my electorate. I removed all the spam, group emails and emails from people who were not from my constituency, and focused on people who took the personal time to contact me, write to me or email me. Interestingly, my data shows a different result. It came in at 58.9 per cent of people being opposed to the bill. These were not necessarily emotional approaches. This contact was from people who took the time to personally write to me to share their experiences both for and against. As I said, there were arguments made on both sides that I found myself agreeing with, which is causing me a lot of challenges in trying to work out the right thing to do here. I do not think I could have ever dealt with this bill if the vote had gone down party lines. I would like to acknowledge that at least we as a Parliament and have made the decision that this should be decided on a conscience vote. I believe it is the only way we should approach it. I would like to share an email just to give a sense of the communication I have been receiving and the considerations that certain people have provided. This one is from someone who is opposed to the Voluntary Assisted Dying Bill. It says —

I am a Registered Nurse and my husband is a Palliative Physician and Geriatrician. We have been working in hospitals for many years and have a great deal of experience caring for those with chronic and terminal illnesses. Through good medical and nursing care we have witnessed many patients pass away when nature intended them to, with dignity and comfort. We have also witnessed time and again, the errors medical professionals make in diagnosing and treating patient's conditions. Just the other day my husband discovered the underlying cause of a patient's condition which five medical teams before him had missed. This patient was referred to him for palliative care. It is erroneous to presume that any person is so enlightened and perspicacious they may judge when a life should end.

I urge you to vote against this form of legalised killing.

That is just an example of the types of communication that I have received. This is from someone who is far more professional and experienced on the issue than me. I can only dwell on my personal experiences. It just highlights the challenges that all of us have possibly faced in discussing this issue with our community. As I said at the outset, it is my intention to reserve judgement on this bill until we have gone through the consideration in detail stage. I will not go any further. I have made the key points I would like to make about this bill. I appreciate the contribution of all members of this place and the manner in which this debate has been held.

**MS J. FARRER (Kimberley)** [5.33 pm]: I, too, rise to contribute to the debate on the Western Australian Voluntary Assisted Dying Bill 2019, with the greatest respect that I hold for the differing views of those in the chamber and across Western Australia. I would like to thank my constituents and many others who have taken the time to write to me, email me, phone me or speak to me. I am both impressed and moved by the quality of feedback and arguments for and against the bill. I would also like to congratulate and thank all my colleagues for their informative, heartfelt and emotional contributions to this debate. As members of Parliament we are often required to make difficult decisions and create laws that affect the lives of all Western Australians. To be eligible to access the provisions of the Voluntary Assisted Dying Bill a person would have to be 18 years old; be an Australian citizen or have been a permanent resident of Western Australia for at least 12 months; have decision-making capacity in relation to a decision about voluntary assisted dying; and be diagnosed with an eligible disease, illness or medical condition that is advanced, progressive and will cause death or is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. I am satisfied with the numerous safeguards that this bill has, and I believe they are strict and most appropriate. I, too, share the view that even the best of palliative care cannot always deal with the issue.

Over recent months I have had many discussions with my constituents. I would like to share from my notes a couple of the responses that stood out to me. One person said —

You have to be very careful as an Aboriginal person. If you support someone in assisted dying, you may be seen as helping them to die, and if the family is not ready for that person to pass on, you could be tribally punished.

A second person said —

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As an Aboriginal person, helping someone end their life goes against what we are taught. It goes against empowering our people and our cultural wellbeing, but watching my mother-in-law and nanny in the time when she needed, was suffering and became bedbound was one of the hardest things I have ever had to do. Her frailness still haunts me to this day. I do not know if she would have used voluntary assisted dying, but I do wish she had the choice to be able to access it.

A third constituent said —

I am now a retired nurse, but I have seen the torment, the pain, the loss of control, the loss of dignity and loss of one's self. This is not living.

Right now I would like to tell a little story about a young woman in my electorate and where I came from. She was not even 30 years old. I brought this up in 2015 when we were in opposition in regards to the breast cancer scans around the Kimberley in the breast cancer bus. I asked a question. It was at the time when the Minister for Health was Dr Kim Hames. I asked whether some of our young women could have this breast screening done, because there were problems with some of them. The answer I got was that they had to be 40 years old or over to have it. I respect that, but I think sometimes some of those policies or laws need to be reviewed and changed. The reason I asked that question was this young woman. She was only 30 years old, but she had done lots of work on some of the pastoral stations up there. It was at a time when she worked on the Kidman brothers' property. She was a very reliable young woman. She was not married and did not have kids. The way this young woman passed has always haunted me. She was shooing a horse one day and she said something freaked the horse out and the horse ended up kicking her. It kicked in the breast on the left side. She was on one of the outstations of the Kidman brothers' station, and she was taken back to the main station and then to Halls Creek to have some medical attention. She had an open wound from the horse's kick. She was seen to by the doctor at that time. We have a lot of doctors who are there on locum, so they do not really know much about Aboriginal people's history and their medical history. She was flown from Halls Creek to Darwin and she was up there for a few weeks. When most of our people come back from hospitals, they are put on Greyhound buses, so members can just imagine if a person is suffering and they are put on a Greyhound bus. She came home and the doctor said to her that she was okay and she could go home. She went back out onto the property that her parents lived at. She constantly had a weeping in her breast. She went back and saw the doctor again and they placed her in one of the wards of the hospital, and that is where she lived. The time frame of this happening was not even eight months. The parents asked me, "Josie, why didn't somebody do something about this?" As the mother said, for a woman with problems with her breasts, surely somebody should have done a lot better. I said that I did not have the answers, but I would table this, and I did that. I asked the Minister for Health at the time in Parliament about it. I took the answer back and gave it to the parents. The father was not very impressed with the answer, but there was no advice about where they could go. It was a big letdown for me as the member for Kimberley and as an Aboriginal person—knowing those families and giving them that advice.

I asked whether they could go back and talk to the doctor again. But the doctor who had assisted her at the beginning had gone back to wherever he came from because the doctors were locums. There was no tracking history of what the medical side had given her. When people go in with health issues and checks with doctors, there is all that stuff about confidentiality, so her parents were not able to acquire a lot of information from the doctor. She started getting sicker and sicker, so she was placed back in the hospital in Halls Creek, where she was given a ward where she stayed. She had the company of her younger sister, who slept with her in the same bed and was always there to make sure she was given her medicine and to assist her with anything else. She sent word with her mother for me to go and see her. Having known her since she was born, I was not feeling too happy about going to see her because I knew the condition she was in, but I ended up going. Most visitors were not allowed to see her, but when I asked to, they had to ask permission and she said, "Yes, I want Mum Josie to come and see me." I am not her mum, but that is in our tradition. When I walked through the door of the ward she was staying in, her eyes lit up. She was lying there and looked very frail. She had a great big smile on her face and was very happy to see me and that I had come to visit her. I walked over and put my arms around her and said, "I've come to see you because your mum sent word that I needed to come and see you." She said, "Mum, thank you for coming. I've been sick. But my greatest ambition as a young woman with the work I am doing is that I want to go to Canada to compete in the Calgary Stampede." That is a big dream for some of our young kids. She asked me whether my son was still in Canada and I told her he was. She asked me to contact him and let him know that she wanted to go there to compete. We had a talk and I told her I would ring my son and let him know. I rang him and he told me that he would look after her if she came over.

I came back down for Parliament, so I missed her for a couple of weeks. When I came back, they told me that she had been flown to Perth. There was a very short time from when she was diagnosed when she got hurt until then; it was July to November. She had to come back to Halls Creek and I went to see her again. At that time she was

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permanently living in the hospital ward. She said to me, “Mum, did you tell brother that I’m going over to Canada? Because I really want to go and compete in that rodeo.” She was a young woman who competed in rodeos. She also starred in the movie *Australia*. I do not know whether anyone has seen the movie, but she is the young woman in the red dress who was riding a horse. Her greatest ambition was to go to Canada and compete in the rodeo. She asked me whether I had told him and I told her I had. She said, “When I get better, I’m going.” I asked whether the doctor had told her anything more about how bad she was. She sort of smiled and said yes. When her mother came into the room, I asked her whether the doctor had explained to her and her husband about what she was going through and whether this could be a terminal illness because of the contribution of what took place. She said, “No, we do not know nothing.”

When we talk about voluntary assisted dying, there needs to be not only consultation but also interpreting services. In the Kimberley we have a hugely diverse range of language groups. To get this message out, there has to be a lot of consultation in place. There need to be interpreting services and people who can speak different languages. In this case, the mother could not understand a lot of the medical jargon when the doctor was talking to her.

It is a really sad story because all she wanted to do was do what she dreamt about, but that was not for her. She had Christmas in hospital with her family around her. They came from the outlying communities where her family lived—Yiyili, Bayulu, Fitzroy Crossing, and even from Balgo. I think they could see that she was not going to make it. As Aboriginal people we look after each other and share our pain. We share any information; even though in the health and medical world it is all confidential, as Aboriginal people we talk about it. Her family all shared Christmas with her in the hospital. Each time anyone went to visit, she always had a smile on her face. Even though she went through a lot of pain, she was able to deal with that in her own way. For me as an Aboriginal person, this bill has been particularly challenging. Where I come from it is our belief in our traditional culture that if a person receives assistance in passing on, their spirit will be trapped. We believe that when it is your time, it is your time. However, I stand in support of this bill because I believe it is the right thing to do and I support people having the right thing to choose, which is a big difference between our cultural beliefs and the western world that we live in.

One of the many reasons I became a politician was to try my very hardest to expand people’s opportunities to have choices. I do not believe that voluntary assisted dying is a matter of choice between life and death. I believe it is a choice for those who are going to die. There is a difference between how we see things in our traditional culture and how they are seen in the western world. I have personally seen the effects that it has had on quite a number of young people and older people for whom death is inevitable and imminent, but this woman’s story inspired me to talk about the difference in how we see things. I still believe that if this legislation is ever to be endorsed, let people have the right to make that choice. Choice is a big thing in life; we all go through life making choices. You make choices as to whom you want to marry, you make choices whether to have kids, and I believe that if your time has come and you know that you are going, you should have the right as a person to make that choice. That was just one of the sad stories, but it also gives us an understanding of what some people experience.

Once again, I would like to say thank you to everyone who has taken part in this debate. Hopefully, we can make legislation that will make people’s lives a lot easier. As Aboriginal people, we love to be buried back in our own country, because we have a very spiritual belief. I would like to see some more exploration of that because, as I said before, as an Aboriginal person your spirit goes back to where you come from. That is our belief. It does not matter what anyone thinks, that is our belief. As Aboriginal people we have a very spiritual belief and we need to make sure that this is understood. Thank you.

**MR S.K. L’ESTRANGE (Churchlands)** [5.50 pm]: All of us in this place and all the people in our communities have a view on the topic of voluntary euthanasia. I want to take this opportunity to thank the many constituents and non-constituents who have reached out to me to offer their thoughts in regard to this matter. I have received many impassioned pleas to oppose this bill, and I have received many impassioned pleas to support this bill. Notwithstanding the differences of opinion in the eyes of the community, there will be rights, wrongs and consequences linked to either outcome with regard to how we, as a Parliament, choose to vote on this legislation. The test for each MP when voting along conscience lines is to make a genuinely informed decision that they believe is in the best interests of the community and the state they serve. That is why I, like many members, have listened to constituents and read their letters and emails. I have also attended information briefings, met with medical practitioners and sat down with palliative care experts to hear their views.

Another source of understanding of life, death and suffering that makes us think about voluntary euthanasia is, of course, found in our own lived experiences. For me, I had the challenging experience of witnessing my mother being diagnosed with breast cancer at the age of 36 and given two years to live—a time span she hid from my sister and I at the time. I was 16 and my sister was 13. Our mother received the best medical care and we got on with life as a family, as normally and as positively as possible. In the end, she died just short of her forty-second

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birthday, beating the two-year diagnosis by three years. She put on a brave face and pushed on throughout her cancer journey so that the reality of her impending death was concealed from my sister and I for much of the time. Her brave fight and the medical support that extended her diagnosis by three years meant she got to see my sister and I graduate from school, both attend university, and my graduation from officer training. In the end, she received palliative care up to the point at which she declined further futile treatment and, in her final days, received the best possible relief from symptoms so as not to prolong the dying process.

My father lived on for almost another 30 years, but he, too, had to deal with cancer on three separate occasions over an 18 to 19-year period. The first was bowel cancer when he was about 60. It was caught late, but it was dealt with before it was able to spread to other organs. He was on a colostomy bag, receiving chemo, and struggling on as best he could, but with a very positive outlook. He always considered living to be better than the alternative, and he fought hard to beat off the cancer, again with excellent medical help, and succeeded.

Ten years later he was diagnosed with prostate cancer; this time, he had grandchildren. Again, his fighting spirit and treatment—albeit uncomfortable and painful—also saw this cancer off. But at age 75 came his biggest challenge, when he developed cancer in the lower back. He received intensive chemo, which made it very difficult for him to eat as the skin in his mouth was burning. He did his best to blend nutrients and eat through a straw while living alone, and he fought hard, but his body deteriorated and he went from being a big man of 95 kilograms down to 65 kilograms. My sister and I at Christmas that year had a private chat; we did not expect dad to last six weeks. However, we underestimated him. His goal was to attend his first grandfathers' day at his old school, to continue to interact with his family and his many friends, and to beat the cancer. Remarkably, he did so, and with his PSA levels down to almost zero after a couple of years, and back to a healthier weight above 75 kilograms, his specialist called him her miracle. He made the grandfathers' day, along with many other family milestones, but in the end, four years after his third battle with cancer, he died of a heart attack in the driveway, fully dressed on his way out to go to the shops and to see friends.

I share these stories because they are examples of the strength of the human spirit in the face of mortal adversity. What concerns me is that had euthanasia been an option for my parents, would it have hung over them like a difficult decision embedded in their subconscious when they were in their darkest hours? Would they have felt the need to access voluntary euthanasia? But it was not an option, and for us as a family, their lives were extended, and many milestones were achieved, shared and enjoyed by virtue of them living beyond what was expected. The reality is that many of us do not like to think about our own mortality. We certainly do not want our end of life to be miserable.

A good quality end to life is an outcome or goal that our health researchers and practitioners strive to make the norm. This goal drives the motivation for new medical discoveries, gives people hope that they will be taken care of, values the ageing and supports families and communities. However, it is the examples of the horrific cases—the small percentage of people who will face incredible pain, suffering and humiliation, for themselves and their families, in the final stages of life when dying of a degenerative terminal illness—that motivates the yes vote for voluntary euthanasia. I, too, am empathetic to the need to help people when they are facing this traumatic end to their lives.

This is evidenced by a Roy Morgan poll on assisted dying and euthanasia taken in November 2017. It states —

... 87% —

That is, of Australians —

are in favour of 'letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery' compared to 10% (down 7%) who say doctors should 'try to keep patients alive' and 3% (down 11%) who are undecided.

The genuine concern I have is that, on the one hand, this bill is motivated to support Western Australians who hold the view that the hopelessly ill, who are experiencing unrelievable suffering with no chance of recovery, will be offered voluntary euthanasia, but, on the other hand, the bill could be open to misuse and capture a broader group, as evidenced by clause 15, under the heading "Eligibility criteria". I am particularly concerned about how people facing chronic diseases, as my parents did, will approach life when this legislation takes effect. What is needed, prior to any serious consideration of voluntary euthanasia, is to explore all options for the hopelessly ill and to properly resource a highly effective palliative care regime that is able to adequately care for people facing chronic or terminal illness. For those over 65 years of age, the possibility of having to deal with one or more chronic life-threatening illnesses rises considerably, and many have to juggle multiple health issues, most of which are considered life threatening. Accessing quality palliative care early is therefore a key support requirement for people facing life-threatening health issues.

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The commonwealth Department of Health makes the point that chronic conditions often lead to a gradual deterioration of health and loss of independence, and are the most common and leading cause of premature mortality. The key chronic conditions in Australia are high blood pressure, Alzheimer's or dementia, heart disease, depression, arthritis, osteoporosis, diabetes, chronic obstructive pulmonary disease, cancer and stroke. The commonwealth Department of Health website notes —

2014–15 National Health Survey data also indicated that nearly a quarter of all Australians (23%), and 3 in every 5 Australians (60%) aged over 65 years, had two or more chronic conditions

It also states —

Chronic conditions accounted for around 9 in every 10 deaths in Australia in 2015. Often more than 1 disease is associated with a death and 3 diseases is the average. About 20% of deaths have 5 or more associated diseases

This data is compelling, but it is the current reality of ageing. As a society, we have continued to work hard at improving health and wellbeing outcomes, with the goal being to prolong a healthy life for as long as possible. Nevertheless, death for all of us is inevitable. The former head of palliative care at Royal Perth Hospital, Professor Doug Bridge, was recently reported as saying —

“The truth is that dying is hard work and unpleasant and causes grief, but that's just normal dying,” ...

Therefore, the most pressing need to support those with chronic or terminal illnesses is to have a highly effective and readily available palliative care service throughout Western Australia. Our focus should be about advancing medicine and procedures to support the patient through to their end of life while their suffering has been negated.

Furthermore, while I have highlighted the effect of chronic illness as a reality of ageing, one of the eligibility criteria under clause 15 of the bill is that the person is only required to be over 18 years of age. I cannot imagine how difficult it would be for an 18-year-old, and their family, to be placed in a situation in which they would need to contemplate voluntary euthanasia as an option. Even when facing the reality of chronic illness, the majority of people will have an intrinsic desire to fight off any illnesses, and to live for as long and as meaningfully as they can.

Therefore, the questions to pose are: What impact will the introduction of voluntary euthanasia have on the sick at a time when we are yet to build up the most effective palliative care regime? How will voluntary euthanasia influence how we as a society support and harness each person's will to live? If we combine these thoughts with the statistics offered earlier on chronic diseases, when we heard that 60 per cent of those aged over 65 have two or more chronic conditions, we can deduce that will mean that in order for more than half the population to live to the current mortality age of 79 to 84, they will have to battle with chronic diseases for up to 14 to 19 years before they die. I offer this perspective because it highlights the need for us to continue to build our society's motivation to support people in the over-65 age bracket, who are dealing with ageing, to assist and support them to look forward to the joys they get out of life, which come from experiences such as meaningful employment, learning, family and grandchildren, travel, friendships and ongoing leisure pursuits. In terms of a person's end of life, most would wish to get to that current mortality age of 79 to 84, or older, with good mobility and a sharp mind, while remaining in close contact with friends and family, being as pain free as possible, and then dying quickly, naturally and without a fuss.

The questions can then be asked: Why can this not be achieved without the need for voluntary euthanasia? Is it a question of resources? A question of concern then follows: will voluntary euthanasia, once enacted as law, have a negative influence over attempts to achieve better non-euthanasia end-of-life care goals and outcomes? We must also then think of the person who is confronted with the reality of impending death. Will voluntary euthanasia devalue life in the eyes of those who are demoralised when confronting a chronic or terminal illness? Will voluntary euthanasia put undue real pressure, or even subliminal pressure, on a person to choose to die prematurely?

These questions drive to the dangers of moving along the voluntary euthanasia path when the eligibility criteria for accessing death are broader than what appears necessary to satisfy the question in the Morgan Poll that I mentioned earlier—that is, “letting patients die when they are hopelessly ill and experiencing unrelievable suffering with no chance of recovery.” We need to think carefully about the impact of the option of voluntary euthanasia on the decision-making of the demoralised person who is living with a chronic or terminal illness.

I will provide some commentary by Anthony Fisher in the *Weekend Australian* on 22 June 2019. He said —

A few years ago I was close to death. I had a severe case of Guillain-Barre and was totally paralysed from the neck down.

I was in terrible pain. I was powerless to feed myself, wash myself, toilet myself. I was a burden on others and didn't want to be. I spent five months in hospital alongside others with conditions such as multiple sclerosis and motor neurone disease who were not going to recover as I might. Some were heroic, some

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demoralised. So I came to understand why some people want early death for themselves or others. I know the humiliations and the temptations of serious illness. I hear the cry: "They shoot horses, don't they?"

Still, I don't think the lethal jab is the way to go.

He said also —

Those who advocate euthanasia say it's about mercy and autonomy. No doubt those are real motives.

But every place that has gone down the euthanasia path has left the frail, elderly, sick and disabled with fewer options, not more; with a less care, not more. It also has encouraged other classes of non-terminal sufferers to consider a state-sanctioned death.

Despite the culture of the quick fix, despite demands for governments or health professionals to make everything nice, some suffering is unfixable.

Then our resilience, our character and our hope are really tested. Then our community's resolve to stand with us, to invest itself in us, not only financially and pharmaceutically but also emotionally and spiritually, is tested. Then the hard loving starts. I have known such hard loving when I was close to death. I ask that others receive it also.

Fisher's commentary should motivate us to see the value in striving for better health outcomes to support the chronically sick and terminally ill. This is where money, research and effort should be placed. This effort can be grouped under the heading of palliative care.

The minority report submitted as part of the parliamentary inquiry, titled "The safe approach to End of Life Choices: License to Care not Licence to Kill", provided the following in finding 3 —

The provision of quality palliative care affirms a patient's right to choose their therapy, decline futile treatment, choose their place of dying, receive the best possible relief of symptoms and to refuse to prolong the dying process.

As outlined by Dr Shane Kelly in *The West Australian* of 31 August 2018 —

We believe that the provision of excellent and compassionate end-of-life care, that alleviates pain or distress, means no person need resort to contemplating assisted suicide.

Sometimes, when diagnosed with an illness, or during treatment, patients will talk to their clinicians and family about a desire for a hastened end to life.

Most often these discussions are driven by a person's fear of being a burden, or feelings of depression, hopelessness, and fear.

Our years of experience in providing end-of-life care demonstrates that with compassionate assessment and intervention, these concerns can be addressed.

Australians have every right to expect that their care needs will be met at each stage of life.

The experiences of pain and suffering should motivate us to do better, with policies and budgets to vastly improve palliative care outcomes.

The report of the Joint Select Committee on End of Life Choices, titled "My Life, My Choice", provided evidence in findings 16 to 20 outlining the parlous state of Western Australia's palliative care offerings. Finding 16 states —

Access to hands-on specialist palliative care is limited for metropolitan and non-metropolitan patients.

Finding 17 states —

Western Australia has the lowest number of publicly funded inpatient palliative care beds per head of population.

Finding 18 states —

There is a gap in care for people who are seriously unwell but not close enough to death to be admitted for inpatient hospice care.

Finding 19 states —

There is limited access to palliative care medical specialists in regional Western Australia.

Finding 20 states —

There is limited medical oversight, coordination or governance of medical palliative care services across WA Country Health Service."

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I believe that before we, as Western Australian legislators, cross the euthanasia Rubicon, we must do all in our power to improve our medical end-of-life care outcomes, so that pain and suffering is managed to a point whereby euthanasia does not need to be an option. However, if recent media reports are anything to go by, it is anticipated that the state Labor government has the numbers to pass this voluntary euthanasia bill through this chamber and possibly the Parliament.

As I said earlier, I am empathetic to the need to support people who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. Efforts should be made, possibly through legislation, to work closely with the palliative care sector to see what more can be done; for example, in the area of terminal sedation.

Bethesda Health Care, at page 4 of its response to the parliamentary report titled “My Life, My Choice”, states —

Bethesda asserts that ‘terminal sedation’, as a primary aim, is not consistent with good care at the end of life, but recognises care and treatment intended to manage troubling symptoms may have a secondary sedating effect. Bethesda supports the Committee’s recommendation to the effect that ‘terminal sedation’ should be clearly defined, and that clear guidelines be developed for the use of ‘terminal sedation’ should be developed and implemented.

Bethesda Health Care goes on to say —

... Bethesda (consistent with the latest evidence and our extensive clinical experience) proposes that the suffering of most people who are approaching death is ameliorated (or even eliminated) when they access quality palliative care in a timely fashion. Further, Bethesda notes the Committee’s own findings that access to quality palliative care within Western Australia is highly variable, and encourages the Government of Western Australia to continue to invest to improve the health system’s capacity to support people at the end of life, their families and friends, and the broader community.

Only when all palliative care efforts and endeavours have been exhausted, and all terminal sedation methods explored, should we as a society look to the concept of voluntary euthanasia. However, it should be tightly controlled through the prism of supporting those who are hopelessly ill and experiencing unrelievable suffering with no chance of recovery. That is because to cross this euthanasia threshold early brings with it inherent risks, as evidenced in countries around the world which have decided to move in this direction.

The minority report submitted as part of the parliamentary inquiry, titled “The safe approach to End of Life Choices: License to Care not Licence to Kill”, provided a large number of examples of where, once the legislation had been introduced, irreversible errors were made, eligibility criteria were softened, and efforts to support the sick and dying were weakened. Time does not permit me to go through them all but I will paraphrase and provide some examples, quoting from my notes —

Finding 31: Redress in any assisted suicide case is an impossibility.

Finding 32: The presence of undue influence can be difficult to identify and is easily missed.

Finding 76: The Dutch courts incrementally increased the scope to include adults with psychiatric illness.

Finding 77: In 2001 the Netherlands extended euthanasia to allow for children as young as 12, subject to parent consent.

Finding 80: Doctor shopping in the Netherlands has become commercialised with at least one organisation providing assisted suicide to patients whose own physician has declined.

Finding 81: The Netherlands is debating whether euthanasia should be extended to those who are ‘tired of life’.

Finding 90: Similar to the Netherlands, Belgium allows assisted suicide for patients diagnosed with a mental illness.

Finding 94: Belgian physicians, the subject of a peer-reviewed study in 2010 confirmed the use of life ending drugs without an explicit request from the patient, including because they considered discussion would have been harmful or because they considered the decision was in the patient’s best interest.

Finding 98: In Switzerland in April 2013, a retired Italian magistrate, aged 62, was assisted to suicide on the basis of a terminal illness diagnosed by Italian and Swiss doctors only for an autopsy to find no terminal illness.

Finding 103: In the first nine months following the passage of an assisted suicide law in Quebec it was found the law had been breached in 21 cases. In the second year of operation, breaches occurred in 31 cases.

I will conclude with extracts from an article by former Prime Minister Paul Keating titled “Voluntary euthanasia is a threshold moment for Australia, and one we should not cross”, published in *The Sydney Morning Herald* of 19 October 2017. It reads —

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There is probably no more important issue in contemporary bioethics or a more serious ethical decision for our parliaments ...

This is a threshold moment for the country ... 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.

The justifications offered by the bill's advocates—that the legal conditions are stringent or that the regime being authorised will be conservative—miss the point entirely. What matters is the core intention of the law. What matters is the ethical threshold being crossed ...

An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project—the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.

No law and no process can achieve that objective. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system. Beyond that, 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 ...

Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society.

**MR K.J.J. MICHEL (Pilbara)** [6.14 pm]: I rise to make my contribution as the member for Pilbara to the debate on the Voluntary Assisted Dying Bill 2019. I commend the Minister for Health and his department for their evident hard work in bringing the bill before the Assembly. It is clear that the bill is a result of extensive consultation across the state, building on global debates on the issues surrounding end-of-life choices over the last couple of decades. I thank the minister for bringing the consultation to the Pilbara earlier this year. I have also requested that my constituents contact me to provide their views, and I thank those who have taken the time to email me and speak to me on this issue. This bill is very hard for me to speak on. Like many others, I did not have the opportunity to be with my parents when they died. I have not had the experience of seeing anyone suffering in pain before they died. I pray to God I do not have to go through what others have gone through. I cannot say honestly that I feel people's pain, as it is their experience, and not mine. But, as a human being, I have feelings.

Noting the sensitive nature of this bill, I am pleased that this government took the time to develop the legislation and that significant consultation was undertaken as part of the two major reports that preceded its drafting, those being the report of the Joint Select Committee on End of Life Choices, "My Life, My Choice", tabled on 23 August 2018, and the "Final Report of the Ministerial Expert Panel on Voluntary Assisted Dying", chaired by Malcolm McCusker, AC, QC, which was tabled in Parliament on 27 June 2019. This bill poses ethical questions for many of us in the community—the terminally ill, their families, healthcare professionals, religious leaders, concerned citizens and us, the members of the Legislative Assembly who will vote on this bill in consideration of the views of our electorate. It is important we take the time to debate and consider the issues involved.

As many members are aware, I am a committed Christian. For me, this debate is a balance between the doctrines of my faith and providing choice for those who are suffering. As followers of faith, we are taught about the sanctity of human life, that not one of us can take another's life. "Thou shalt not kill" is the fifth commandment that most Catholics live by. We are also taught about the value of compassionate care, the need to look after our fellow human beings, and to care for the poor, the aged, the sick and the vulnerable. Within the Christian community, there is debate, and I have received correspondence from Christian organisations and constituents presenting arguments on both sides of the debate.

In the context of discussing this bill, we need to note the importance of maintaining and strengthening palliative care services. I am pleased that, as part of the 2019–20 budget, this government announced \$47.4 million towards palliative care and end-of-life choices. I hope that there is longevity in this support of palliative care. It is the largest investment to date in Western Australia's palliative care services, and I am particularly pleased with the focus on distributing funding to regional communities. It is vital to maintain and strengthen palliative care and

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continue to focus on improvements to quality of life. However, while pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care.

The legislation before us carries with it an enormous responsibility that all of us in this house have been elected by their constituents to bear. For the debate on legislation concerning matters of life and death, I believe that our constituents should inform our work, not our personal beliefs or our religious faith. The stories that I have heard, the emails I have been sent and the phone calls I have received from my Pilbara constituents are overwhelmingly in support of this legislation. I heard from a constituent who watched her mother-in-law pass away from motor neurone disease last year after battling it for five years. Her mother-in-law knew how she would die during the last five years of her life, yet she had to unnecessarily suffer a completely diminished quality of life. I heard from another constituent who sent me this letter —

Dear Kevin Michel MLA

My husband was diagnosed with Stage 4 terminal cancer in late 2012 and given a best estimate of 3 years. He finally passed away and I hope that he finally found peace, peace from the pain and suffering, in January 2014.

He was 48 years old ... our 3 children, young adults. Each night we would kiss each other goodnight and hope that it would also be good bye. He would say that he was holding his ticket up high—his ticket out. He finally passed away because he simply stopped eating, and his heart finally gave out.

He worried that he was still alive at Christmas time and into the New Year and he didn't want his death to impact on our future family memories of Christmas.

If only he'd been able to choose the day and time of his death.

He was an active man who loved living life and being a part of fishing adventures, sport outings and sharing time with his family and friends ..

I don't know if you've been personally touched by cancer or the death of a loved one from an terminal illness, and if you haven't I hope you never will because the grief and loss will never leave you.

But please please please be a voice in support of this Voluntary Assisted Dying Laws and share my story, and the story of my husband's death.

If only he'd had a choice, if only he'd been able to choose the day and time of his death.

We must make a compassionate choice about this legislation and I must make a responsible choice on behalf of the majority view of my electorate. That is why I am commending this bill to the house.

I would like to finish my submission with an excerpt of a letter from another constituent living in the Pilbara electorate. Debbie Allcott wrote a letter about the incurable, untreatable and very cruel neurodegenerative disease, progressive supranuclear palsy, or PSP—a disease that took the life of her mother. In her letter Debbie wrote —

Over an 8 year period PSP rendered my mother fully incontinent, gradually and eventually unable to move at all, unable to see because her eyelids shut for the last two years of her life due to the palsy, eventually unable to speak at all and unable to swallow without having constant near death experiences. She suffered the type of end of life she had always tried to avoid with her "living Will" and documented boundaries of what she considered "living". She did not believe in feeding tubes to keep one alive when in an incurable, terminal state, nor intubation in such circumstances.

My previously vibrant mother eventually became a 'pulse in a body'. This to her, was indignity and irremediable suffering and it could not be described in any other way. Her journey was long, arduous, cruel. She endured so much as she lost all of herself meaning her last 6–12 months were simply inhumane and heartbreaking. No one should have to endure such an ending that is inevitable and she desperately had wanted to choose a more gentle, dignified end.

Palliative care couldn't give her back the dignity she'd lost. Nor could it help her move again, or see again or eventually speak again. These are people's inner values and soul that allows them to enjoy living. The previously "love of life and vivacious, smiling woman" was trapped and no one could fix or change that, not even palliative care. And because of archaic laws she had no option but to suffer it out, even though this is an incurable and terminal disease.

As an intelligent, compassionate and progressive society, we now have a chance to debate and change this in a positive way for our most vulnerable.

Debbie finished her letter with the plea that I ask other members of the house —

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ask yourself privately, “if that was me OR, if that IS me .... would I not at least feel comfort in the ability to have a choice?”

Thank you.

**MR W.J. JOHNSTON (Cannington — Minister for Mines and Petroleum)** [6.26 pm]: Thank you very much. As a member of the cabinet of the McGowan Labor government, I have scrupulously avoided making any comments on the Voluntary Assisted Dying Bill 2019. I want to say that I am determined to be bold, brave and compassionate in deciding how I vote on this legislation. It appears to me that this bill is likely to pass the Assembly and, most likely, it will pass without amendment.

Equally, I recognise that all the evidence is that, overwhelmingly, Western Australians support the passage of the legislation through the Assembly. That is probably true of my own community of Cannington. However, it is also true that only a small number of people beyond the Parliament have actually read the bill. I imagine that very few people know what the terms of the bill mean. In fact, many of the people who have contacted me to say that they support the bill did so because they believe the bill provides for euthanasia. That is not a surprise, given that much of the commentary around the bill has been set out in terms of individual self-determination. Indeed, the report of the Select Committee on End of Life Choices was titled, “My Life, My Choice”. The title suggested that the committee recommended that people should be able to choose to die when and how they want, when that is not the effect of this bill.

Over many years, I have listened to many people discuss voluntary assisted dying and euthanasia and speak about many things, including what is called rational suicide—that is, the concept that a person should be able to access voluntary assisted dying regardless of their health condition. The argument is that if a person is of sound mind, without limit, they should be permitted to choose the time and circumstances of their passing. Further, I have been lobbied by people to support this bill on the basis that they should have the right to end their life via the use of advance health directives in the case of dementia and other conditions that do not of themselves lead to death. That is not unusual, as recommendation 23 of the Ministerial Expert Panel on Advance Health Directives final report, which was tabled by the Attorney General only this week, recommended that.

As many members have pointed out in their comments, many constituents have been in touch with us to say that this bill does not go far enough. Of course, that means that the passage of this bill is not the end of the debate. There will continue to be a debate on end-of-life choices notwithstanding the passage of this bill. It is also true that this is not the first time the question of voluntary assisted dying and euthanasia has been considered by the Parliament.

On each of those occasions, the Parliament decided to reject those bills. The criticism that has often been made to me in the lead-up to this vote is misdirected. Parliament has a duty to consider these issues. Parliament had considered these issues but had chosen not to take this step. The decision by the Parliament to reject those bills is said by some to be a failure. Effectively, there is an argument that a decision to not support this bill is an invalid choice. Indeed, it has been put to me that if a parliamentarian chooses not to vote in favour of this legislation, they are acting inappropriately. I have been told that if a parliamentarian does not support this bill, it means that that individual parliamentarian instead supports inflicting pain on another person. I have been told that because the majority of people support the passage of the legislation, opposition is not valid. I have been told that opposing this bill means that a person is supporting suicide. This is despite the fact that the suicide rate in Oregon increased after the introduction of assisted dying legislation. Indeed, I have been told that having a religious perspective on the bill is also an invalid approach.

I would like to make the point that roughly an equal number of constituents on both sides of the debate on assisted dying have sent me their perspective. I appreciate that this appears not to be true for every member, but there has not been an overwhelming demand for me to support the legislation. This may be because I have not sought to make an issue about my views. Alternatively, it might also reflect the large number of Islamic, Catholic and Assembly of God believers who live in my constituency. I would like to make the point that there are people who make their decision on this bill from a religious perspective, and they are entitled to do so. Further, another valid view against this legislation is that it is not appropriate for the state to authorise the death of a human being, and that is personally the perspective I take. Other people have raised their opposition to the bill on the basis that it misdiagnoses the challenges of end-of-life choices. I have had workers from palliative care facilities explain to me that they oppose assisted dying because they believe it is unnecessary. Also, there are people who argue that the bill should be opposed because effectively it is the “thin end of the wedge”. Of course, people have lobbied me in favour of this legislation, telling me that none of these arguments are legitimate. I do not agree with that. It cannot be correct to argue that our entire history of society has been wrong. I do not agree with that perspective. The law in this state does not permit assisted dying, so I fail to grasp how supporters of this legislation can say that selecting the status quo is not a valid selection.

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We should consider some issues when looking at this bill. The number of people accessing the laws in jurisdictions that introduce voluntary assisted dying or euthanasia grows over time. As I have highlighted, this bill does not satisfy many people's views on access to assisted dying. There will continue to be a campaign, including by many of the people who have been involved in high-profile lobbying in favour of this bill, to extend access to assisted dying to more categories of people. It is important that we all note that the Australian Medical Association does not support this legislation. It has been reported that the AMA opposes this legislation, with an article stating —

The Australian Medical Associations across the country believe that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.

I turn to a number of specific provisions in the bill. Clause 10 of the bill provides that a health practitioner cannot tell a patient that there is a better way to be treated than to access voluntary assisted dying. Clause 10 states —

A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.

That means that if a patient comes to a health practitioner asking to access voluntary assisted dying, the practitioner cannot say to them, "I understand that you are eligible for voluntary assisted dying but I think there is a better pathway to manage your specific illness." If a practitioner says this to a patient, the health practitioner is potentially guilty of professional misconduct. I do not think that is appropriate. This is particularly the case when clause 112 proposes that a person is protected from liability for assisting a person in making a request. So, a person is protected from liability in supporting or encouraging access to assisted dying, but a medical practitioner is not protected when recommending against voluntary assisted dying, even if their medical opinion is that there is a better healthcare option for a patient than assisted dying. Clause 19(5)(b) requires a medical practitioner with a conscientious objection to provide information on how a patient can access assisted dying.

The bill will also impact medical schools, which will need to include education on voluntary assisted dying in their medical programs. I am unconvinced that this issue is appropriate to be included in the legislation.

I would like to make it clear that I do not believe that there should be any artificial delay in bringing this bill to a final vote. However, I also want to let the minister know that I have some specific questions that I will raise in consideration in detail to clarify some of the provisions in the bill and to ensure that those issues are recorded in *Hansard*.

In conclusion, I make the point that this is a conscience vote. Each of us must make our own decision on how we vote. As Edmund Burke said —

Your representative owes you, not his industry only but his judgment; and he betrays instead of serving you if he sacrifices it to your opinion.

It is my judgement that this bill is not suitable to be supported and I will vote against it.

**MS J.J. SHAW (Swan Hills)** [6.36 pm]: Perhaps somewhat naively and very early on in my political career—in fact, as a candidate and very early on in my preselection—I was asked for my opinion on voluntary assisted dying. I very quickly and very publicly voiced my support for it. Reflecting now on how I felt then, it is funny how simple these issues seemed at that time and how easy it was for me to express an opinion—a view that seemed logical and absolutely self-evident. But now I have to make a decision, not just express an opinion, about the lives of people whom I have been elected to represent, about the sort of state I want to live in and the types of values that we as a polity and a community should uphold and preserve—a decision that will affect people that I care deeply about and that affects my own family.

It is one thing to roll off an opinion about the types of choices that we as an individual would like to make about our own life and the sorts of rights we think should be available to others. It is quite another thing to be placed in the position in which we have to make a decision—this decision—because the decision that I take as the member for Swan Hills, the decision that this Parliament will take on behalf of the people of Western Australia, can help or hinder so many others to make decisions about their own lives. This decision is probably the most profound I will ever have to take as a legislator. I have no doubt that all my colleagues in this Parliament appreciate the gravity of the matters that we are now considering.

The past couple of days have borne witness to some of the best work I have ever seen any Parliament undertake. As a new member of Parliament, I am proud to be part of this institution that has debated these matters in a considered, measured and respectful way. We are considering whether and how best to safely and compassionately respect and facilitate an individual's ability to freely decide to die with dignity in circumstances in which people face an

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[ASSEMBLY — Thursday, 29 August 2019]

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inevitable and imminent death and are suffering in a way that they consider intolerable. This process has shown me that decisions on these matters are not lightly taken. Like my colleagues, I have searched my conscience and thought about this day and night. I found myself genuinely challenged to examine my moral and ethical beliefs. I have also undertaken extensive consultation with my electorate to ensure that I understand the views of the people I am so privileged to represent and on whose behalf I will make decisions through this debate. Death touches us all. Death comes to us all and it confronts us all. It is very uncomfortable to talk about, and perhaps as a society we are not very good at talking about it.

During this debate, we have all heard about members' personal experiences of suffering and grief. Listening to stories about suicides in particular has been very harrowing. It is tragic to hear the coroner's comments that 10 per cent of suicides are linked to chronic disease and terminal illness, including deaths from plastic bag asphyxiation, hanging and gunshot. As the Minister for Health so poignantly stated, these are wrongful deaths. I believe that we can and should do better than condemn people to suicide.

As I consulted with my community on this issue, I also heard many stories of loss; of people who have confronted some terrible circumstances and who are currently struggling with these issues. I want to thank the people of Swan Hills for being so generous and willing to share their views and experiences with me. I conducted a range of different forms of consultation on this topic within my electorate. I ran an online survey, conducted community forums, attended many meetings with community groups, received letters and emails, and had many direct conversations. Overwhelmingly, the people of Swan Hills have told me that they support voluntary assisted dying.

Polling across Western Australia has indicated that 88 per cent of people support voluntary assisted dying. In my electorate, my own survey—which I was at pains to ensure reflected the views of Swan Hills residents—showed that 92.8 per cent of people supported voluntary assisted dying. Of the 2.7 per cent of people who were unsure and the 4.5 per cent of people who were opposed, about half of these expressed the view that they did not consider the proposal extended choices to a sufficient range of people—they wanted the VAD framework to go further.

I want to briefly give a voice to some of the experiences and views that my constituents shared with me. According to my notes, one constituent said —

My personal experience is watching a loved one who has put up a fight, in the end have choices taken from them.

Putting a patient on morphine is inhumane—no food no fluids.

Having a choice that if the disease or prognosis results in death, making the choice while capable should be a right.

Prolonging the process and forcing loved ones to live with the anguish of seeing them in pain, or watching them become so emaciated is also inhumane.

I watched my brother wither away, these are my last memories of him.

Another constituent said —

My Father died a painful and undignified death due to throat cancer.

He was not conscious in his last days and in too much pain to humanly bear prior to this.

His last months were unbearable suffering, with absolutely no quality time to appreciate these last days with loved ones, so much so that he forbade me from visiting him in Melbourne.

My stepfather is now facing the same death to secondary lung cancer. It is beyond cruel to both the individual who is suffering and the family who love them.

Death in these cases is inevitable but we have within our means a tangible way to prevent the heartache associated with the agonising wait for the unpreventable.

Finally —

Having watched my grandmother suffer a terrible debilitating and slow decline in to death, I would not wish that upon anyone. Human life is valuable but quality of life is important too. People should be allowed to accept and welcome their death with grace and dignity.

A small number of my constituents were against voluntary assisted dying. They predominantly based their views on deeply held religious convictions. According to my notes, one constituent said —

I believe that all human life is sacred and to take one's life is a mortal sin in my religion.

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Another said —

I firmly believe that God is the only one to decide a person's time of death and that we should not take it on ourselves to act on God's behalf in this or any other issue.

I respect and acknowledge people's rights to hold these beliefs and to apply their conscience as they see fit when the time comes for them to make decisions about their own lives. I imagine that being a member of the church and holding these views would be of great comfort at a very trying time, but I cannot accept that the views and beliefs of some should prevent others in my community from accessing a safe and compassionate framework to achieve a dignified and gracious death at a time that they decide. I want to acknowledge all of those people who told me that they did not think their own religious beliefs should stand in the way of others' rights to make decisions about their own lives.

There were also those who expressed the view that this legislation does not go far enough. One constituent stated —

My mother's ... greatest fear is a stroke which leaves her incapable of looking after herself.

Her advance health directive includes refusal of resuscitation, however should she survive but be incapable of being independent, she wants the option to end her life as there would no longer be any quality of life.

This situation does not appear to fit within these recommendations and yet is a very real situation that applies to many people.

Another constituent said —

Having seen close family members suffer and decline due to dementia and Alzheimers related diseases, I believe there should be the provision for a person of sound mind to make a "living will" by stat dec which indicates the level of decline that they regard as untenable and that this can be evoked as a compos mentis request in lieu of their ability to yield that assent at the stated time.

As someone who, in real time, is experiencing these issues in my own family, having difficult conversations about the decline of a loved one and facing the prospect of some very challenging decisions ahead, I know how hard it can be to share stories of grief, loss and suffering. I know how heavily the weight of decision lies. I want to sincerely thank all of those constituents who took the time to tell me their stories and give me their views and opinions.

My responsibility as the member for Swan Hills is to give the proposal before this Parliament my objective consideration, which is based on the briefings that were provided to members by the Department of Health and a range of other organisations; the work of the Ministerial Expert Panel on Voluntary Assisted Dying; and the findings and recommendations of the Joint Select Committee on End of Life Choices. I would like to thank the members for Morley, Baldivis and Mount Lawley in this place, and the South West Region in the other place, for their fantastic work on this initiative. In making my decisions on this important issue, I will be informed by these comprehensive and extensive bodies of work and the strongly expressed wishes of my community. I am satisfied that the government has undertaken a comprehensive and methodological approach to developing this legislation. I congratulate and thank the Minister for Health and his staff for undertaking what must have been an extremely challenging task.

I am satisfied that the eligibility criteria is appropriate: a person must be over 18 years of age, an Australian citizen or a permanent resident, and ordinarily resident in Western Australia; they must have been diagnosed with a disease, illness or medical condition that is advanced and progressive and will cause death within six months, or 12 months for a neurodegenerative illness; and the person is experiencing suffering that cannot be relieved in a manner that the patient considers tolerable.

I believe the bill contains robust and rigorous safeguards to ensure that individuals are well informed and understand the implications of their decision; that they are appropriately assessed for eligibility; that they make their choices completely voluntarily and without coercion; that they have access to medication in a safe and auditable fashion; and that they are appropriately enabled or assisted to finally exercise their choice. I look forward to listening to other members' views on the framework during the consideration in detail stage of the bill.

There are three issues about the bill that I would like to briefly address. The first relates to capacity and the view that some constituents have expressed to me about dementia, Alzheimer's disease and advance health directives. Some people have said that this legislation does not go far enough. I believe it is very important that this legislation preserves at its very heart an individual's complete control over the decision-making process at the time that decisions are taken. Whilst I understand, and have directly witnessed, the tragic decline of family members through dementia, I could not support a framework that places decisions into the hands of others about when someone has

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reached that point at which their AHD enters into effect. To me, that undermines the concept of “voluntary”. I believe that capacity and access should be determined in real time.

The second point I would like to make addresses palliative care. This debate is not about a choice between voluntary assisted dying and palliative care. Although it is legitimate to call for increased access to palliative care, and I am very pleased to see that significant action is being taken by the government to improve resourcing, the two issues should not be conflated nor traded off against one another. The bill stands alone and we should consider it as such. For some conditions, palliative care simply cannot provide relief, and the only person who should determine whether pain is insufferable is the patient.

The third point relates to conscience. It is appropriate that if a medical practitioner has a conflict of conscience, they should be able to refuse to participate. I note that there are provisions requiring that practitioners must provide information to patients when they exercise their conscience. My constituents are concerned to understand how this framework applies beyond individual practitioners to institutions, and whether institutions may be able to prevent access—particularly public hospitals funded by Western Australian taxpayers that are intended to provide public health services to us all. The main public hospital available to my constituents is operated by a religious organisation. It does not permit women to access the full range of reproductive health choices available to other women at state-owned and operated public hospitals, based on conscience. My constituents will be very interested to understand how the provisions of this bill will ensure that they can step through the stages of the voluntary assisted dying framework, particularly to attend clinical consultations with medical practitioners at their only local, state-funded public hospital. Constituents have also raised concerns about access at aged-care facilities operated by religious organisations and their ability to exercise choice when they may wish to die in their home surrounded by loved ones. I look forward to exploring these issues through the course of consideration in detail.

This legislation will give people the ability to die with dignity when their life may be devoid of it. It will provide the ability to exercise choice and have control, and will perhaps provide peace at a time when, otherwise, life would be filled with fear, uncertainty and pain. It will allow them to be supported, have their freedom to decide respected and be surrounded by their loved ones in a place of their choosing as they exit this life. I want to congratulate the government for having the courage and the conviction to bring forward this bill on a topic that has vexed so many other jurisdictions. The passage of this legislation would bring this Parliament into step with community expectations. It would be a significant step for us as a community, and warrants detailed consideration and debate, but the Parliament must let this legislation come to a vote. Our community also expects that of us. We have a duty to make a decision, and it is my sincere hope that it will enable others to make their decisions. I want to assure the people of Swan Hills that I have listened to your views, considered this matter in great depth, searched my conscience and reflected deeply on my role as your elected representative. I have thought long and hard about the profound responsibility you have given me to make a decision in this place on your behalf that will have far-reaching consequences for our community.

I commend the bill to the house.

**MR P.C. TINLEY (Willagee — Minister for Housing)** [6.52 pm]: I rise to make comments in a very careful way on the Voluntary Assisted Dying Bill 2019. It was not my intention to address the second reading of this bill. The reason for that was that I felt there was just going to be a line, if you like, of people giving successively repetitive orations of the same experiences, but in fact, I found it was entirely the opposite. I felt compelled to make a statement about how proud I am to be a member of this chamber—how proud to have heard members speak from deep knowledge, deep experience and deep conviction. It is not often that we get the opportunity in this chamber to hear such heartfelt and deeply held views, and some uncertainty I must add. There is a vein of uncertainty across this chamber about what this bill actually means. People in the electorate ask me how I will vote on any of these life matters—whether I am pro-choice or pro-life—and that is just not helpful. More often than not I say that I do not have an answer because I will answer when I am asked to vote, and I will make a decision about the sorts of things that go into my vote on the basis of the evidence. Until we are in that position, in that moment when we have to make a decision on behalf of our constituents in the state of Western Australia, then, and only then, do we have the responsibility to answer that question sincerely. We cannot have a simplistic debate about these topics.

The contributions I have heard—I have not heard them all—have filled me with pride, based on the sort of contemplation people have had. I acknowledge the member for Dawesville in his leading off, I suppose, after the Premier and the Minister for Health. His contribution was highly researched and highly thought through, and it reflected his community. I also acknowledge the contribution of the member for Armadale, who gave me some pause, I must admit, around some of the issues of the vulnerable and their vote. As is so often the case in any legislation, we are trying to contemplate the unintended consequences of a bill. We are also trying to contemplate the unintended consequences created over a generation after the implementation of a bill, with the changing nature

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of technology, people's attitudes and the community. In many ways we are trying to second-guess that by creating legislation, as we do every day in this place. I want to mention in this small contribution the pride I have in other people's contributions. I acknowledge the courage my friend the member for Cannington had in standing and delivering the sort of conviction he has on these issues. It was not just a simplified yes or no, but an articulated view of what his concerns are and why they are so important. Of course, the generalised respect across this chamber has been something to behold. Now, the challenge for us is to carry that same sort of respect into the subsequent stages of this bill as it passes through our chamber, making sure that when things are brought to a point of choice, should there be proposed amendments or otherwise, we can continue that good intention.

The other reason I wanted to make a contribution was that in some way I feel slightly compelled to be on the record as being part of a significant part of Western Australia's political and public policy history. My constituents have an expectation that they know where I stand and what I do or do not do on a particular bill. For the most part, we on the government benches do not get to speak on every bill. We are not required to or the bill is not in our area. Having listened to other members, this is one of those times I feel compelled to make sure I am recorded in *Hansard* on the decisions that are important to so many people in my electorate. Like many members here, I have been approached. I have not actively canvassed too much, but when people or groups have wanted to talk to me, I have made myself available. I am very clear about those views from the electorate, so I am quite comfortable that I will be representing the majority of the views in general terms. But we are not here to vote on general terms; we are here to vote on detailed terms. The sorts of contributions made by members have given us some excellent evidence to discuss and debate the exact terms by which this bill will come to book. The vast majority of our constituents would not have contemplated the detail of how the vulnerable will be attended to in this legislation and the practical implementation of it. It is upon us, particularly in consideration in detail, to tease that out.

I will conclude on this: in my previous professional life I have been responsible for taking life. I have sent many into harm's way. It is not ever of itself a decision taken lightly. I urge everyone to contemplate the professions and the professional people who surround themselves every day with those people who are dying—those people they have in their hands to care for. Do not underestimate the level of care, commitment, intention and professional approach they will take to each and every human. Life is not taken easily, regardless of who you are, particularly if you are a professional, and particularly if your entire professional life has been dedicated to the preservation of life. It is not a decision you take lightly. Some of the details around the actions in this bill and the consequences of some of its clauses need to be nested inside the professional conduct of an outstanding class of citizens in this country, and that is the healthcare workers—all of them. Please put some faith in them to understand the sorts of things they are doing every day.

Like many in this chamber, I have had a personal experience with this. My mother was a devout five-foot-four Catholic woman, who commanded eight children with a wooden spoon, a strap and a stern look. She died at our home in Kardinya surrounded by her family, weighing something like 30-odd kilos, ravaged by bone cancer and all the other attending cancers that come from a life of smoking. I am not sure that she would have chosen voluntary assisted dying in her final days, but I sure as hell know that, fierce woman that she was for individual choice, democracy and the sort of civil society she raised us all to belong to, she would have wanted that choice. She would not have wanted it denied to anyone else. That is why I support the intention of this bill and its smooth passage through this chamber. I thank you all for the opportunity.

Debate adjourned, on motion by **Mr D.R. Michael**.

*House adjourned at 7.00 pm*

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