

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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## VOLUNTARY ASSISTED DYING BILL 2019

### *Second Reading*

Resumed from 29 August.

**MS M.J. DAVIES (Central Wheatbelt — Leader of the Nationals WA)** [4.02 pm]: I stand this afternoon to speak to the Voluntary Assisted Dying Bill 2019. I admit that I do so with some level of anxiety. Surprisingly, I have a greater level of anxiety than when, as a newly minted member of Parliament, I spoke in the Legislative Council nine years ago, to Hon Robin Chapple's Voluntary Euthanasia Bill 2010. That bill was debated only in the Legislative Council, and was not supported to proceed any further at that time. It was a private member's bill, but every member in that place afforded it the due consideration deserved by such a serious subject. As a new member, and a young member—in fact the youngest in the house at that time—I approached that debate by conducting my own research and inquiries. I met with palliative care specialists, and with Marshall Perrin, from the Northern Territory who, by chance, is here in the Parliament today. I attended briefings and consulted with my electorate, Agricultural Region. It was a very different bill from the one we are considering today, and it had a vastly different pathway to the Parliament in comparison with the bill that is before us. However, I cannot say that the details or the parameters of that bill, or the way that it was developed, were the overriding reasons I chose to vote against it. In 2010 I did not support voluntary assisted dying. As a legislator, it was my view that the bill did not contain the appropriate safeguards, the legal clarity or the protections, but as an individual I could not or would not be convinced that we should legitimise a practice that would allow some people to choose to die with the aid of another. I was worried about the moral dilemmas that this would create for everyone surrounding the person making the request.

Now, nine years later, I find myself delving into this most complex issue for the second time as a member of Parliament, this time as the representative for the good people of the electorate of Central Wheatbelt. I have attended meetings convened by the Parliamentary Friends of Palliative Care. I have attended briefings with doctors and nurses from jurisdictions where this legislation has been introduced. I have met, albeit briefly, with Hon Malcolm McCusker and members of the ministerial expert panel. I have spoken to palliative care practitioners, nurses and doctors in my electorate. I have met with Mr Andrew Denton and representatives of Dying With Dignity. I have listened to all 17 hour-long podcasts from the series created by Mr Andrew Denton, titled *Better Off Dead*. As a country MP, I spend many hours in my car, and it was a good opportunity to listen to the sometimes harrowing stories that were recounted, in the privacy of my own space, along with the forensic manner in which Mr Denton scrutinised the arguments for and against voluntary assisted dying.

I note that members who have spoken prior to me have talked of town hall meetings as part of the consultation on the bill with their electorates. I have the privilege of representing an electorate that spans 100 000 square kilometres. It contains 27 local governments and twice as many towns and communities. I have done my very best to communicate with my electorate about the bill, and, before that, the work of the ministerial expert panel, and, before that, the inquiry and report of the parliamentary committee. I have invited comment and feedback and provided information directly to groups and individuals who have considered the matter. As result, I have received emails and letters into my office, contact via social media platforms, and communication with me directly at field days and local shows, mobile electorate visits, and events that I have attended, no doubt like every other member of this place.

Over the 10 years I have represented the electorate, first as the member for Agricultural Region, and now as the member for Central Wheatbelt, I have come to appreciate that the people who are the bedrock of these communities are both pragmatic and compassionate. I will not distil the electorate into one homogenous entity—it is far more complex than that—but it is true to say that many country people, particularly farming families, face the practicalities of death in some form far earlier than their city cousins. Whether it is humanely ending an animal's suffering as a result of illness or injury, or slaughtering a chicken or sheep to put food on the table, the circle of life is very evident on a regular basis for many of my constituents. Indeed, I have lost count of the number of times that people have said to me that we do not allow animals to suffer unnecessarily, so why should we tolerate this for our family and our friends. I make a strong point here that this sentiment alone is not enough to warrant support for the bill, but this pragmatism that filtered through many of the conversations I have had over the past months in anticipation of this debate has rung true for me. I heard comments such as, "Why make them suffer when death is inevitable and near?", "Why don't you let me decide when I've had enough, Mia?", and "I wouldn't let one of my much-loved pets suffer a cruel and painful end." Another said that the legislation does not mean that more people will die; the legislation only ensures that fewer of them will die suffering. Another said that we believe that if you are nearing the inevitable end of your life and suffering, the best option for the individual is to peacefully just go to sleep. I also received heart-wrenching correspondence from constituents who felt compelled to share some of

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their most private and painful moments. The experience of watching someone you love suffer is hard to bear in normal circumstances. To watch someone you love suffer when there can be no outcome other than death, knowing this is inevitable and the only release, is hard to bear. One constituent wrote —

The suffering he has and will continue to go through is ripping not only my heart out but also my mother's and three sisters I can see the pain in his eyes and he has already communicated to us that he no longer wants to continue. He deserves so much more than an undignified death.

Another wrote —

Having to watch your mother disappear and her shell of a body left to wither away for years is something I don't want my kids to go through as I did. My father had cancer and he too wanted only to die in peace, something that was not allowed to him and he died after 2 years in agony both emotionally and physical.

As we all began to talk about this in earnest after the parliamentary committee had reported, I was visiting the Northam Health Service to inspect the upgrades, which are almost complete. I was walking through the emergency department, which is really quite wonderful, and a lady and her daughter were in one of the treatment bays. The mother was in the bed, and she called me over, out of the blue, grasped my hand—I did not know her—looked me straight in the eye and said, “You must support this voluntary euthanasia bill, Mia.” Her daughter looked very upset and nodded, but when I asked her whether she would like the option, she simply said, “Yes, mum's had enough; this body of hers is worn out, and she's ready to go.” So many people are watching this debate. I do not know that woman personally, but the people who have reached out as part of this conversation have been quite remarkable to me, as a local member of Parliament, right across the state.

Sometimes my electorate is incorrectly characterised as conservative or resistant when it comes to social change. I am not altogether sure whether that label is correct, or whether it has ever been.

Pragmatic, a strong sense of self-determination and self-reliance, and compassionate—this is the wheatbelt that I know. You see this in the way these communities operate—volunteering and fundraising extraordinary amounts to make their towns a better place to live. We have aged-care facilities and independent living units for our senior citizens in towns with populations of sometimes fewer than 300 people. These existed well before the advent of royalties for regions and support from the state government in more recent years. They were built through donations, by hard graft and by everyone chipping in. As I speak about this, I would not like the Premier or the Minister for Health to get the impression that the demand for these facilities and services has been met—far from it. But I make the point that we in the wheatbelt have always been prepared to invest our own funds to look after the people who have built and contributed so much to our communities. Each generation is acutely aware that it has a responsibility to look after those who came before them, and leave it better for those who follow. For a number of towns, this burden is carried by a diminishing number of people, and yet that has not stopped them from wanting to provide the best care and support for those who are vulnerable in their old age, or facing a disease that may rob them of their quality of life. When death comes—as it does to everyone—in the wheatbelt, funerals are a whole-of-town affair, with generations of family, friends and neighbours returning to pay their respects. It is very literally the embodiment of the definition of compassion—a word that means “to suffer together”.

I have considered the notion of “compassion”, because I spent some time thinking about what this means in the context of providing the end-of-life option of voluntary assisted dying, and many have referenced that during the debate already. In 2010, during the debate on the Voluntary Euthanasia Bill 2010, I made the following statements about a compassionate society —

In my view, it is one that cares equally for the young, the elderly, the sick, the infirm and the vulnerable. It is one that affords an individual dignity and respect in illness and health.

I used these statements to argue against voluntary assisted dying, saying more resources should be allocated to palliative care and support for those suffering at the end of their life. I now believe, with the benefit of the good work done by the parliamentary committee, and numerous discussions with those who have worked in this field, that this should not be an either/or debate.

In 2010, I spoke about my pop and my nan, and their passing. Since then, my grandad has passed away, and also my dad. Pop, nan and dad all had cancer, and my grandad—my mum's dad—had Alzheimer's. I do not know what their views were on voluntary assisted dying, and it is not my place to speculate. Had this legislation been in place, my pop, my nan and my dad would all very likely have been eligible for voluntary assisted dying. What I can do is reflect on their life and passing from my perspective. In my pop's case, I remember him from my childhood as a strong man and a leader in his community, who had the respect and love of his family. I considered it a great privilege to be part of a family that drew in around him to care for him in his last months. In that time, a different

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relationship developed between him, his grandchildren, his daughters-in-law and his six sons. Where once he was robust, he was vulnerable. Where once he was thinking only of the next job to be done, he was reflective.

Pop received wonderful support, at one time being admitted to the Cottage Hospice in Shenton Park, stabilised, though wonderful palliative care, and then returned home, where his palliative care was provided until his death, surrounded by his family. So naive was I about how the system worked that at that time I thought that once you entered the hospice and were under a palliative care specialist, you would shortly be shuffling off this mortal coil. I was one of those people whom the parliamentary committee highlights at paragraph 3.28 of its report, and I quote —

Unfortunately, there remains a misconception that palliative care is just for the final days or weeks of life or only for people with cancer. Many patients and their families are reluctant to involve palliative care in their treatment out of the mistaken fear and misunderstanding of what it represents.

As we have heard from other members during the debate, palliative care can significantly improve and even extend a patient's life. At least it can provide a quality of life that is comfortable for most patients.

There is a reason that much of the “My Life, My Choice” report completed by the parliamentary committee focuses on palliative care services, funding, staffing, education and awareness. Palliative care is, and will always be, an important service. Improving these services across Western Australia—overcoming the challenges of making sure every Western Australian can access appropriate palliative care—must remain a priority of this and future governments. This is of particular interest to me as the Leader of the Nationals because the delivery of these services into our vast and sparsely populated regional areas is truly a test for any government. But we can do this and also consider voluntary assisted dying. I know I am a better person, and my family are better people, for having known my nan, my pop, my grandad and my dad, these wonderful people in different stages of their lives, in both strength and vulnerability. I also know through their experience that the human body and mind can withstand much more than we ever think it can. There is an indomitable spirit and will to live, even in the grimmest of situations. It is a human condition to want to live.

My dad wanted to live. On days when he could barely breathe, he still wanted to be there to see his beloved grandkids, Harry and Ella. What I cannot gloss over is that when death is imminent, and the disease that our loved ones have fought so valiantly has got the better of their body, providing a choice to go gently and peacefully under their own terms is what I consider compassionate and just. I cannot say whether dad wanted that choice. I never discussed it with him, probably because in his mind he was never going to die! I can tell you that if I was faced with a diagnosis of lung cancer tomorrow, I would want the option of voluntary assisted dying. I would also want access to the support that palliative care can provide for the patient and family of someone with a terminal illness. If I was given the right to choose, and went through the process of applying, it would also be my right not to use the drugs provided. I do not agree that providing people with the option of voluntary assisted dying relieves us of our responsibility to look after our most vulnerable. I think it does exactly the opposite. In fact, there is strong evidence across the world that it does exactly the opposite.

Many people do not and will not consider death or dying until it arrives on their doorstep. They may not have had the experience of watching someone they love die a “bad death”. Many will likely not read the deeply personal accounts provided in the committee's report, or have that firsthand knowledge that many medical staff will have about how death comes to patients with terminal disease. We are not a society that talks about death. But we should. This bill should mean that there will be more conversations, more checkpoints, and more access to support and advice.

It was with great interest that I listened to Andrew Denton interview a woman, Marjorie Vangansbeke, from Brussels, who had been suffering unbearably for many years with a mental illness. In that jurisdiction, she was eligible to access voluntary assisted dying. I know this is not being contemplated in Western Australia, and it is certainly not something to which I want to widen the debate, but the conclusion that Mr Denton arrived at, having discussed the process that applied to voluntary assisted dying, was interesting to me. Marjorie made the decision to apply for voluntary assisted dying, having suffered for many years. The first doctor she spoke to referred her to a specialist and she came to understand that the process was not in fact the free pass to death that she had been hoping for. She worked with a psychiatrist, and they diagnosed Asperger's and developed a plan for living with the condition. Six months down the track, her thoughts had shifted from committing suicide violently, to living. Andrew Denton, at the conclusion of the interview, observes, “It is a paradox I had never considered before: how embracing the prospect of death can hold out, instead, the possibility of life.” Instead of suffering in silence, of believing that there is no option but for a violent death at your own hands, the option to discuss a gentle death in fact opens up opportunities for people that they may not previously have been aware of or considered. At the very least, there is a discussion about death and end of life in a supportive and reasonable environment.

I am convinced by the evidence provided to the parliamentary committee here in Western Australia and the evidence from across other jurisdictions that we would be failing our community if we allowed the status quo to

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remain. At this stage, I would like to refer to the comments of Andrew Denton in his final podcast of *Better off Dead*. I urge members who have not listened to this podcast to take the time, if they can, to listen to some of the work that was done as part of preparing this podcast. He states, according to my notes —

The point of changing these laws is not about forcing an outcome on anyone. It's about giving them a choice—a level of control—when illness and suffering is robbing them of other choices and control. It's about the comfort of having options. And it's about respecting other people's choices too. Those who disagree are free to live, and die, as they choose. Doctors and nurses who feel the same way have every right not to participate. A law for assisted dying is not about a right to die—as one Dutch doctor put it to me “death is not a right; death is a fact at the end of life”—but, instead, a right to ask for help should the suffering become unbearable and untreatable.

[Member's time extended.]

**Ms M.J. DAVIES:** There are still some questions for the government to answer in relation to this legislation and I hope that it will undertake to consider them all seriously. Firstly, I have already raised with the Premier the issues about the commonwealth legislation that has caused the Victorian government to restrict all discussions between a patient and doctor to face-to-face interaction. There will be logistical challenges for regional Western Australians to access voluntary assisted dying should it have passage through this Parliament. The use of technology, particularly telehealth, will play a vital role in access to both voluntary assisted dying and palliative care. If we are to limit discussions between doctors or healthcare professionals and patients to face-to-face interaction, we will immediately disenfranchise regional and remote Western Australians. We must have assurances from the minister that the concerns we have raised have been addressed. Secondly, there is little clarity at this stage on the implementation of the legislation, particularly from a regional perspective. Again, I point out that we have a shortage of general practitioners in regional Western Australia, and that shortage extends to allied health practitioners, including nurse practitioners. Will a person who accesses voluntary assisted dying have the same time line for the process as someone living in the metropolitan area? I suspect not, given the logistics and the size of our state. Certainly, if we rely on Australia Post for the delivery of the voluntary assisted dying substance, then I would say absolutely not, given that it takes me nearly three weeks to get a letter from one end of my electorate to the other. Is it fair that if a person has been approved to access the substance and is living in unbearable and insufferable pain, they will not have access to the drugs due to logistical reasons or implementation issues? I want to be clear in this debate that although there are those of us who agree with the principle of voluntary assisted dying, me being one of them, it is not a free pass for the government to gloss over the details, especially when we know from experience that any service delivery into our regional and remote areas comes with unique challenges. At all times we should strive for fairness and equality. There are too many examples of regional Western Australians being disenfranchised, marginalised or simply put in the too-hard basket for every government by trying to implement policy across a state the size of WA. A person's geographical location in this state should not prevent them from accessing voluntary assisted dying if they are deemed eligible.

I would like to finish by commending the committee for the comprehensive report and work that was carried out as a precursor to this bill arriving in the house. It would be a fair observation to make that there would be few, if any, pieces of legislation that have had the same pathway to this Parliament. I would also like to thank those who provided evidence to the committee, and again to the ministerial expert panel. It was harrowing to read some of those very personal accounts, so I can only imagine just how difficult it was to present them in public. It would be awful to think that those people would have to return and do this again at some point in the future. To everyone who has contacted me about this bill, especially those from my electorate of Central Wheatbelt, I thank them. I realise that not everyone will agree with the position that I have taken, and I respect the views of those who do not support the bill and have taken the time to express those views to me in person or in writing. I am pleased to offer my support for the Voluntary Assisted Dying Bill 2019. I do so knowing that I have been on the public record opposing voluntary assisted dying in the past, particularly in the 2010 debate in the Legislative Council. However, I believe that my decision today reflects the wishes of the majority of my electorate and it is by their good grace and support that I stand here today. I commend the bill to the house.

**MR W.R. MARMION (Nedlands — Deputy Leader of the Opposition)** [4.23 pm]: The Voluntary Assisted Dying Bill 2019 that I rise to speak on today is certainly the most confronting and difficult piece of legislation I have had to consider in the 11 years I have served the people of Nedlands in this place. I have close friends with strong views and legitimate arguments for the case either for or against voluntary assisted dying. Like all members of Parliament, I have been lobbied by emails, letters and personally in the street and cafes, and, indeed, in most meetings over the past years, I have often sought the views of constituents whilst I had that opportunity. Before I outline the process I have been going through to determine which way I should vote on this landmark piece of legislation, which challenges a range of philosophical notions, including ethical, political, let alone cultural and

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religious, I note that this bill has been introduced coincidentally with the recent death of my father. It has certainly been poignant to assess the bill given these circumstances. However, I have been able to integrate the merits of this bill in real time, having a father who passed away only on 14 August, and the funeral two weeks ago on 21 August. My father was nearly 93 and died peacefully in my presence. He leaves my mother, who turned 90 last Thursday, with dementia, which is another issue that is often raised in reference to this bill and was also raised by the Leader of the Nationals WA.

In terms of my personal thoughts on euthanasia, or, more appropriately, voluntary assisted dying, I have always been concerned about the morality of such a path and what impact legislation to legalise it could have on our society as a whole, and the meaning we place on life. This has been an issue, I will admit, I pushed to the back of my mind for some time because it challenges my ability to intellectualise all the concepts it brings up. I have always sought the sanctity and structure of mathematics, science and engineering, which, for my brain, were much easier to analyse and determine with either factual answers or, at a minimum, risk-based options that are quantifiable. This confronting debate has forced my mind to explore areas I would much rather avoid. I have been very lucky to have been around death only in circumstances in which passing has not been painful. In fact, in all the cases, it was peaceful, although one instance was extremely distressing for all those, including me, who had to stand by and watch death occur. But even in this distressing event, I did not notice the young deceased suffer any pain, as I watched on with fellow workmates.

The one area of my life in which I have always been more than lucky has been that of a Wittenoom resident. As the lead speaker of the opposition when supporting the government's Wittenoom closure bill, I recently mentioned that I lived in Wittenoom Gorge between 1956 and 1960, when the main asbestos mine was in full operation. Many miners and their families who lived in Wittenoom died from asbestosis or mesothelioma. I know that as the years go by my likelihood of getting mesothelioma diminishes, but when growing up it was always a possibility for all my family. To date, none of my family or I have had any signs of this terrible disease. I had the privilege of visiting the research laboratory of Professor Bruce Robinson, and his team, at QEII Medical Centre in 1994, who at the time was trying to come up with a cure for mesothelioma. I met patients who did not have long to live and were being given all sorts of experimental drugs, including interferon. It was distressing, shocking and heartbreaking to see the skinny frames of the mainly ex-Wittenoom residents, especially when some of them said they remembered me and my family. The thought of these residents having to experience a painful death just because they lived in Wittenoom still haunts me, as members can see.

In looking at the case against this bill, I received some very persuasive letters from people I know well. Floreat Medical practice is in my electorate and its principal, Dr Rosanna Capolingua, wrote to me following her presentation, along with Dr Michael Gannon, to the Parliamentary Friends of Palliative Care committee, of which I am a member. In a letter she made the following points. According to my notes, she states —

*“Death may be an outcome of age, sickness or disability, but until now it has never been part of the treatment regime. This societal change fundamentally changes the goals or care for the patient and further empowers the doctor in the relationship as they have the power to offer and apply death as a treatment.”*

In her letter Dr Capolingua goes on to say —

*“When death becomes a treatment option, the patient may well miss out on treatment because the ability to end life prematurely is present.”*

Perhaps her main concern is covered when she says —

*“With increased longevity it has become more obvious in my general practice that apprehension of death of parents or elderly relatives where a benefit (financial or otherwise), will be realised, is a serious problem for our society. The elderly are often physically and emotionally dependent on offspring or relatives and are only held to ransom.”*

In her conclusion, Dr Capolingua summed up her position and the case against this bill by saying —

*This is more than being about the one individual's right to choose. This is about the societal and cultural shift that will adversely affect the many.*

From what I have read, the most powerful intellectual position put for the case against the bill is probably that of former Prime Minister Paul Keating when he wrote —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society... In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators

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to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

For me, Paul Keating captures the essence of my concern about the path this bill takes our society and the very reason that it requires this Assembly and our Western Australian Parliament to give the matter and the wording of the bill our utmost and careful consideration.

I turn now to the case for supporting the bill. Again, I received many emails and letters and had conversations in my electorate with people urging me to support the bill. Most of these were respectfully worded, which is one aspect of this debate that I must recognise as this is not always the case with other issues of much less significance.

At this point I thank the members of the Ministerial Expert Panel on Voluntary Assisted Dying, led by Malcom McCusker, AC, most of whom were present to give me a personal briefing on their recommendations for the drafting of this bill. I must admit that until the government listed the names of the people on the expert panel, I was cynical, thinking that they were simply going through the motions and that the panel would be made up of people who were already strong advocates for voluntary assisted dying. I knew Malcolm for many years before I entered politics, and similarly Penny Flett. I have also met many of the other members over the years and recognise their professionalism and integrity. The panel's report, "Ministerial Expert Panel on Voluntary Assisted Dying: Final Report", with its 31 recommendations, has formed the basis of the bill before us. No doubt during consideration in detail, aspects of those recommendations will be explored in the wording of the bill.

I received slightly more emails from people in my electorate who support voluntary assisted dying than from those who oppose it. However, in my casual meetings and at events when I asked people about their position, most seemed to be in favour. Like all members of Parliament, I received a letter from Doctors for Assisted Dying Choice urging me to support the bill. According to my notes, it states —

With overwhelming public support, your constituents are expecting this Bill to pass. It is stressed that under the proposed legislation, VAD will be voluntary—that is, a matter of choice. This bill is too important to too many people to allow it to fail.

I have known one of the signatories of this letter, Dr Roger Paterson, for many years from our school days. I know Roger to be an intelligent and objective person, and I respect his position on this matter. Likewise, I respect people such as Professor Michael Quinlan, who does not share Roger's view on this bill. Michael is a former vice chancellor of Notre Dame University and, along with Roger, is also intelligent, objective and a person of immense integrity. So how can two people of great intellect and integrity have opposite views on this bill? Therein lies the dilemma for the politician who is not the expert, trying to determine the best outcome for the people of Western Australia.

In the end, despite my "litmus paper" feel that over seventy per cent of my electorate—the people who voted for me to represent their views—were probably in favour of voluntary assisted dying, I still did not have a sound view of the actual numbers in Nedlands. Consequently, I commissioned an independent survey of my electorate and asked people the following questions. Question 1 was: do you know what voluntary assisted dying is? Question 2: do you think voluntary assisted dying should be legalised and available to a patient who desires a painless termination and where a doctor has confirmed they have only six to 12 months to live? Finally, question 3: would you like to see your local member of Parliament support or oppose voluntary assisted dying legislation for Western Australia?

This survey was undertaken just last week and carried on into the weekend. The data results were put together yesterday morning, so it is as current as possible. I would like to read the results. It covered many suburbs in my electorate. I have a breakdown of that but when we look at the breakdown, it becomes less significant. Question 1 was: do you know what assisted voluntary dying is? We do not often get a result like this. We found that 97.6 per cent knew what voluntary assisted dying is. Of those surveyed, 1.9 per cent had heard of it and only 0.5 per cent of people had never heard of it. That is a very strong indication that the public, certainly in my electorate, know what voluntary assisted dying is. Question 2: do you think voluntary assisted dying should be legalised and available to a patient who desires a painless termination and where a doctor has confirmed they have only six to 12 months to live? I might point out that it took a while to get that question right with the survey team to ensure that people were not led in any way. I did not think the first draft of the question was right. The results tie in with other polls; they were similar to the 50 per cent polling done by the member for Dawesville and also the poll in *The West Australian*. The percentage of people who said yes was 85.50. The percentage of people who did not know was 6.8, and 7.7 per cent said no. That was quite a surprise to me because my litmus test was about 70 per cent, so it was a lot more than that. The other question that I wanted to clarify as a local member was: would you like to see your local member of Parliament support or oppose voluntary assisted dying legislation for Western Australia? It went down a tiny bit. We found that 82.1 per cent wanted me to push for the yes vote. Interestingly, the percentage of people who

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did not know went up to 10.6 per cent. I do not know what that means. A total of 7.2 per cent said no. I am not sure what the researchers would make of that.

Before I conclude with my comments on the survey, I will talk about the demographic, which is important. A total of 207 people were polled. There are more females than males in my electorate—51.1 per cent females and 48.9 per cent males. The survey results skewed to females, which is probably because it was a phone survey and maybe females answer the phone more than men; I do not know. The survey sample profile was 62.3 per cent female and 37.7 per cent male. If we analyse the data, the survey was skewed to females. The age break-up was also skewed to the over-65s. My electorate has roughly 40 per cent of people aged between 18 and 39, about 40 per cent aged between 40 and 64, and 20 per cent are aged over 65. The sample profile of the survey for 18 to 39-year-olds was only 20 per cent, unsurprisingly. Only 20 per cent of the sample were aged between 18 and 39; we were right on the money with those aged between 40 and 64, with 40 per cent; and 40 per cent of people surveyed were over the age of 65. What does that mean? By gender, 92.3 per cent of males were in support of voluntary assisted dying and 81.4 per cent of females were in favour. My results were skewed very conservatively. If we had more males in the sample, we would expect the figure of 85.5 per cent to have gone up.

The other area that we looked at was the breakdown of the age group. Again, the survey that I commissioned was 85.5 per cent, skewed with an older population. In the 18 to 39-year age group, 95.2 per cent were in favour of it and 4.8 per cent against. There were no “do not knows” in that group. In the 40 to 64-year age group, 86.6 per cent were in favour of it, 6.1 per cent were against, 7.3 per cent did not know and in my age group of 65 plus—I should not advertise that—79.5 per cent of people were in favour of it, 10.8 per cent were against and 9.6 per cent do not know. That is the result of my survey, and, being an engineer, I think it is quite useful from a quantified point of view. The result of my survey shows that no matter how we wish to break up the various demographics of my electorate, there is overwhelming support for voluntary assisted dying.

[Member's time extended.]

**Mr W.R. MARMION:** Although this was not part of my survey, my constituency expects my support to be based on adequate controls and safeguards around the operation of the legislation. Some of the specific issues that need to be explored in consideration in detail and on which I will seek further advice from the minister include the rationale around the decision not to include the safeguard of the Victorian legislation that does not allow a doctor to initiate a conversation with a patient on an option for voluntary assisted dying. I think that was also mentioned by the Leader of the Nationals WA. Some other concerns were raised by many constituents on the protocols of how pharmacists will dispense the lethal medications and, once dispensed, how the process will be controlled, what safeguards there will be for storing the lethal medication before use and what will happen to the material subsequently. I also want to know what programs will be put in place to ensure that training of medical practitioners occurs. Will there be specific funding and how will this work in remote communities, where access to medical practitioners is limited? Finally, it is certainly my experience, although limited to family and friends, that palliative care is an essential component of the dying process, and that when it is put in place, it definitely improves quality of life for the dying person and reduces any pain. However, I agree with the member for Warren—Blackwood that the inadequacy of palliative care throughout our vast state is a serious issue, but that is a separate debate from the one we are having today. As mentioned in some of the papers I have read, although palliative care, properly provided, can reduce pain associated with death in the majority of instances, there are times when this is not the case. This bill is about providing those people who have a terminal disease or illness the choice to decide whether they wish to access voluntary assisted dying. It is clear that the people of the Nedlands electorate overwhelmingly support this bill. It is also clear that they expect me to represent their wishes in this house.

**MR A. KRSTICEVIC (Carine)** [4.42 pm]: Today I rise to talk about an extremely confronting topic that has a strong possibility of impacting every Western Australian either directly or indirectly—the Voluntary Assisted Dying Bill 2019. I start by acknowledging the enormous task undertaken by the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying. I have no doubt that the process was confronting and emotionally draining for all the staff and members of the select committee. The committee report is 286 pages long, while the minority report has 248 pages. Both reports were very informative and definitely gave me a lot to think about as I worked through each section. It would be fair to say that very few people in the electorate of Carine have read this report or the current bill before the house. The ones who have contacted me and encouraged me to support the legislation will be bitterly disappointed that its narrow focus will not help them in the circumstances they discussed with me. To be eligible under the current bill, a person will need to have reached 18 years of age, have fewer than six months to live or 12 months for a neurodegenerative disease, have decision-making capacity and be suffering in a manner that cannot be relieved. Ultimately, a person needs to convince two independent

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doctors that they have met all the required criteria and that they support the request. Otherwise, they will not be eligible for voluntary assisted dying.

It is incumbent upon me, as a legislator, to act in the best interests of all of my constituents and the people of Western Australia during the course of this debate, which is why I attended a number of briefings and information sessions to get across this very complex area. I can honestly say that I initially struggled to come to a firm position on this issue; however, it became very easy once the legislation was introduced into the Parliament. It is interesting that a number of people have brought religion into the debate, both now and during the extensive select committee stage. I will not do that, as I have tried to approach this from a legislative, electorate and state perspective, bearing in mind that just over a dozen jurisdictions around the world have similar legislation and that, after Victoria, we will be only the second Australian state to have it. Victoria's legislation was recently implemented, and the first person went through its process only a few weeks ago.

Before I go into the detail of the bill, I would first like to talk about its title and public presentation. The glossary of terms in the report of the Joint Select Committee on End of Life Choices defines "euthanasia" as —

... the intentional termination of the life of a person, by another person, in order to relieve the first person's suffering.

"Euthanasia" is defined by the European Association for Palliative Care as follows —

A physician ... intentionally killing a person by the administration of drugs, at that person's voluntary and competent request.

The association defines "assisted suicide" as —

A physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person's voluntary and competent request.

The Voluntary Assisted Dying Bill 2019 allows both euthanasia and assisted suicide, and refers to both practices collectively as voluntary assisted dying. I understand why the committee did not want to label this bill more accurately with the terms "euthanasia" and "assisted suicide", as the community's view on suicide is clearly understood and no doubt the conversations would have been much more difficult. Having lived through a number of personal and distressing situations, I have a very strong view that we need to do everything in our power to take the thought of suicide out of people's minds by providing the best possible health care. We need to urgently increase our investment in suicide prevention; otherwise, the current alarming trend upwards will continue unabated.

It is important to note that the Australian Medical Association does not support this legislation in its current form and believes that doctors need to improve the quality of people's lives rather than end them. Unfortunately for doctors, the minister has put most of the responsibility and accountability squarely on to them, not to mention the penalties if they get it wrong or do not follow the process correctly. It was also noted in the minority report that suicides did not reduce in Oregon after its euthanasia bill was introduced, and as such I am very concerned about the mixed messages we are sending to the community, especially to our most vulnerable and young Western Australians, who suffer depression and other mental health issues in great numbers.

I see at least two very serious issues before us today. Firstly, people with terminal illness who cannot access euthanasia or high-quality palliative care will continue to commit suicide because their needs are being ignored. Secondly, if the state government legalises euthanasia and assisted suicide, we will be sending mixed messages to our young and vulnerable people. Will they understand and accept that it is okay to end one's life only if one's circumstances fit within the proposed legislation? During the course of this debate, many members have said that people should have choice and that these decisions are voluntary. Who is the government to tell people that they cannot end their lives in a dignified way? I understand the points people are making; however, such statements, if taken literally, make me concerned about the possibility of an increase in suicides once it is common knowledge that the government has allowed some people to make this choice while others are not allowed to. Numerous speakers have indicated that about 10 per cent of all suicides are because of terminal illness. If the minister is able to tell me, I would be interested to know whether this is true and how many of these people he thinks might qualify for euthanasia under the proposed legislation.

Many members have spoken about what people in their electorates have told them, and I can honestly say that I have not been inundated by emails or phone calls from people who strongly support one view over the other. Communications have been almost evenly split. When I did a mathematical calculation, approximately 40 per cent of respondents supported euthanasia. Surprisingly, 70 per cent of submissions were unique and not the usual template submissions we all regularly get on environmental issues. As I made my way around the electorate, one-on-one conversations on euthanasia were infrequent unless I directly raised the issue with people. When I held

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large community events with seniors, at the end of each session I asked people to give me a show of hands on their support for euthanasia, albeit that they knew nothing about the specifics of the legislation. On these occasions, a strong majority of people supported the concept as long as the legislation was well drafted and had guaranteed protections. I will say that 100 per cent of people agreed that people should not have to suffer during the last part of their lives and that, as a society, we have social and moral obligations to make sure that everyone has access to the highest level of care. It would not surprise many in the community that we have failed people in this respect.

Even without taking into account the future strong growth in number of our ageing population, it is evident that governments may never be willing to invest the required amount of money in palliative care or the health system generally. We must never forget that the price of not getting this investment right will be catastrophic for future generations. There are currently only 15 palliative care professionals in Western Australia. This equates to 0.57 palliative care professionals per 100 000 people, although we need more than two professionals per 100 000. We urgently need 52 palliative care professionals to meet current demand let alone future growth, not to mention all the necessary support services. We cannot forget the continued complexities in regional Western Australia. People who live in the regions should not be forced to move to the city for treatment. The state government's supposed commitment to palliative care has only recently been increased to \$206.2 million over the next four years. It is important to note that funding details provided by the member for Girrawheen during her speech show that this investment will not all go to palliative care, and the government is being deliberately misleading with its announcement. Prior to this still woefully inadequate investment in palliative care, there had been negligible commitment in this area by successive governments; therefore, it is no wonder we are having this debate today.

I will quote some extracts from an article in *WAtoday* from 28 August 2019, titled "West Australians should not ponder euthanasia due to lack of care": End of life specialists" and written by Nathan Hondros, which covers this area perfectly. It states —

WA's most senior end-of-life care specialists have said they are worried the state's most vulnerable people might consider euthanasia because of an alarming lack of resources available for palliative care, especially in the regions.

... palliative care specialists have said no Western Australian would die in pain if the state allocated adequate funding to specialist care.

WA Palliative Medicines Specialist Group chairman Anil Tandon said only one in three Western Australians who needed specialist palliative care had access to it.

...

Royal Perth Hospital only provided specialist palliative care during office hours ...

According to the doctors, WA has the lowest number of publicly funded care beds per capita in the nation.

Dr Tandon said it was no coincidence that states with the worst palliative care were often the most supportive of euthanasia.

"If we join those two issues together, the current investment in palliative care and the current demand for euthanasia, what we see is that the two states with the lowest funding for palliative care are Victoria and Western Australia," ...

In the current budget year, the state government spent just \$12 million on palliative care in regional WA, an increase from the year before of about \$5 million.

...

According to information provided by the WA Palliative Medicines Specialist Group, there is only one visit a year to the Pilbara by a specialist.

There are six one-week visits each year to the Kimberley, 10 one-day visits to Geraldton and 12 a year to the Wheatbelt.

In the Goldfields, a palliative care specialist visits Kalgoorlie for one day a month and once every three months to Esperance.

Bunbury has two specialists who run a 10-bed hospice and an outpatient clinic.

In Albany, there is one palliative care physician funded for six hours a week, with only three hours a week to run an outpatient clinic.

The University of Notre Dame's Chair of Palliative Medicine Research David Kissane said the state needed an extra \$100 million a year spent on palliative care.

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This is on top of the extra \$40 million for palliative care over four years announced by the government in the state budget.

...

“And there are challenges for palliative care because this state needs another \$100 million injected into it to deliver quality palliative care, so the government is choosing to finance assisted dying over really building up and developing better palliative care.”

Professor Kissane said palliative medicine could successfully treat people suffering from hopelessness and despair.

...

“They treat their depression, they restore their morale, they build them up again.”

...

Professor Bridge and Dr Tandon said specialist palliative care medicine could alleviate the kinds of suffering reported by some pro-euthanasia campaigners.

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

Dr Tandon said the lack of specialist resources meant palliative medicine was sometimes only available when it was too late to make a meaningful difference.

“And there’s nothing that saddens us more than when we receive a referral to help someone, to provide palliative care and it’s almost too late in the course of that person’s illness to make an effective difference to the outcome,” ...

The doctor said there was no need for a patient to die in intolerable pain, if palliative care was properly available.

...

“For us, around about 1 per cent of people have very severe and unremitting terrible distress and pain.

“In that situation what we have spoken to the McCusker expert panel and legislators about is that there is already a legal option and a legal treatment for these people and that’s the use of deep sedation at the end of life.

“So we don’t leave people untreated; ...

Professor Bridge was particularly critical of the state government’s euthanasia bill.

“The sad thing is that people who use this possible legislation I think will be very disappointed,” he said.

“They’ll find it is bureaucratic, difficult, complex [and] doesn’t achieve what they want.

“I think it’s just tragic that even with the best intentions, it’s chaos. The bill is disorganised, contradictory.”

Another area of concern is the possibility that telehealth services may conflict with commonwealth legislation and will, if allowed, have its own complications. It is difficult to reconcile the giant leap we are taking here today, when we are coming from a very low base, rather than taking an incremental approach by, firstly, identifying the gaps and closing them, and, secondly, identifying the best way forward once we have an understanding of the situation facing us and the options available with proper care and funding. One should acknowledge that continued advances in medicine will offer inevitable solutions. One hopes that these advances will occur quickly and banish the need for this solution to the pages of history.

People have referred to the 102 protections in the legislation. However, those of us in this place who have taken the time to look at them properly know that many are just eligibility criteria, and there are really very few substantial protections. Interestingly enough, the Victorian legislation has banned doctor steering, which means that a doctor cannot start a conversation around euthanasia if the patient has not raised it first. Unfortunately, our legislation does not provide this critical protection to vulnerable Western Australians. Alarming, allowing doctors to initiate conversations about euthanasia will put vulnerable patients at risk of undue influence. Inexperienced, incompetent or unscrupulous doctors could lead patients down an extremely dangerous and possibly unnecessary path. Ultimately, doctors could steer their patients towards euthanasia and assisted suicide as opposed to palliative care. It is even possible that a patient’s loved ones might ask a doctor to start the conversation. Loved ones might also be present during the first discussion and might encourage the patient to seriously consider the doctor’s advice, as the doctor knows best.

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The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying acknowledged that up to 60 per cent of Australians have low levels of individual health literacy, meaning that a large number of patients are completely reliant upon their doctors to provide guidance, support and advice about their health decisions. Unfortunately, the bill does not even require the doctor to be a specialist in the person's illness or possible areas of treatment for them to make a decision about a patient's request for euthanasia. During the brief life of the Northern Territory legislation, there was a valid requirement for everyone to undertake a psychiatric assessment. Again, our legislation does not have this critical requirement, which would protect people when they are at their most vulnerable.

I have serious concerns about the physical security of the medication once it is given to the patient, not to mention the possible pressure the person might get from family members to end their life sooner rather than later. There is also the possibility of this medication falling into the wrong hands.

Multicultural considerations need to be strongly taken into consideration. As we know, when people from non-English speaking backgrounds age, they generally revert to their native language and customs, and are thus more vulnerable than most to both coercion and confusion.

The principle of "suffering" is confusing to me, because it seems to not only reflect the principle of physical pain, but also include things like demoralisation, depression, stress, sadness, giving up, loneliness and numerous other possibilities, effectively meaning that anything can be categorised as "suffering".

Doctor shopping and practices specialising in euthanasia also concern me. These behaviours have always and will always take place where this legislation exists. Doctor shopping is a well-entrenched practice in our society.

We know that doctors can get things wrong, let alone guessing the length of time someone has to live. My late godfather passed away from leukaemia. He was originally given less than six months to live. At the time, he spoke to his wife about ending his life. His wife convinced him to fight the disease, and he lasted 17 years before his body gave up. We were told at the time of his death that it was the second-longest battle for life in Australia. He was able to watch his grandchildren grow up, and spend quality time with his wife and kids. Imagine all those lost opportunities if euthanasia were available to him at that time.

Elder abuse is a serious issue in this state, with the current commonwealth inquiry indicating that there are as many as 75 000 victims in Western Australia, not to mention the fact that around 40 per cent of people in aged care never have a visitor. Some of these people could undoubtedly become victims of this legislation. This is something I am not willing to risk.

I am concerned with how it will be decided that someone has capacity, and why a thorough mental health assessment will not be undertaken in every situation to make sure that everything is aboveboard. It is well-documented that people can sometimes present as having capacity, even if they do not.

[Member's time extended.]

**Mr A. KRSTICEVIC:** I wonder what the consequences will be if someone takes their life under this legislation and it is subsequently proven that they did not have capacity. Will people be prosecuted for murder in those situations? What will happen if you have a disease that can be managed but you cannot afford the treatment? Will the state government pay for the people who are not able to look after themselves, or will euthanasia be their only choice? The minister has presented a bill that I consider to be flawed in many respects. My responsibility as a legislator is to make sure that the interests of all Western Australians are protected and that they are not exploited by the government or others in our community. I cannot in all honesty support a bill that will end life while we continue to neglect our obligation to provide appropriate safeguards and healthcare solutions. If the minister was prepared to fund and fix all the problems I have mentioned, I would be willing to reconsider my position.

**MR P.A. KATSAMBANIS (Hillarys)** [5.00 pm]: I welcome the opportunity to debate the Voluntary Assisted Dying Bill 2019 and to exercise my conscience vote on the issue of assisted dying. The legislation before us proposes what is probably the most significant change to our laws and to the ethical framework of our society in my lifetime because it touches on the essential element of humanity—that of life itself. In exercising my conscience vote I have been guided by a number of important factors. I am guided by my faith as a Greek Orthodox Christian. I am guided by my experience in life as a son, brother, husband, and father. I am guided by my professional experience as a legal practitioner who has dealt with vulnerable people and assessed issues such as capacity and coercion in my daily work. I am guided by my experience as a legislator. I am also guided by the very public debate that has surrounded this legislation, and the views expressed to me by many Western Australians, including those in my electorate of Hillarys.

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As a person of orthodox Christian faith, I recognise that life on earth is a precious gift from God that is to be cherished. However, I also do not fear death, as my faith comforts me that death is the essential pathway from earthly life to eternal life through a faithful God and through the resurrection of Christ.

In my own life, until the past few years, my family has been blessed with relatively good health, with the concept of death and dying being more an academic subject than something we needed to confront. My father is almost 90 years old and my mother is over 80 years old. They both remain in relatively good health, and long may that be the case. However, unlike many other families, it has been my parents' children who have had to endure suffering and face up to their mortality over the past few years. These experiences have brought both the physical and the ethical concerns around death and dying into stark reality for my family and myself.

Many people know that in October 2017, less than two years ago, my heart stopped beating. It was not a heart attack; my heart just stopped without any warning signs. I was clinically dead on four separate occasions within a few short hours. It was only through resuscitation and an emergency operation to insert a pacemaker that I am able to still be here today to continue to enjoy life with my wife, my children, my family and my friends. What most people do not know is the aftermath of that life-changing event. My wonderful treating medical practitioners set out to find the underlying cause of what happened to me. I was eventually diagnosed with having a serious infection in my lungs called atypical tuberculosis, which found its way into my system through a still undiagnosed gap in my immune system.

The treatment for the atypical tuberculosis consisted of a cocktail of extremely potent antibiotics, which had severe side effects on me. These side effects were more magnified in the first few months of treatment, but remained throughout the entire treatment period. The severe pain in almost every part of my body, from my neck to my ankles, was excruciating and at times completely debilitating. There were nights when I was simply unable to lie down due to the sharp and severe burning sensations that were shooting through my body for hours on end. There were days when I literally felt like I was dragging a stranger's body around behind me. There were times when I felt helpless and hopeless. Often I would say out loud, "I can't stand this anymore" or, "I can't live this way any longer." Of course, for large parts of this period I was also unsure whether I would actually survive or whether I needed to prepare for the afterlife.

The good news is that I ceased the treatment in April this year and tests show that the atypical tuberculosis is gone. The lingering pain in my body is not gone and is worse on some days than others. Question marks remain around the reason my immune system is suppressed, and I am still highly prone to infection, which makes the debate about vaccination very pertinent and personal to me. Underlying issues with my lungs also need to be clarified. However, I can now approach life and the future with my beautiful family in the expectation of a longer life than I could contemplate less than two years ago. Every moment of every day is a blessing from God that I intend to enjoy for many years to come.

Sadly, my only sibling cannot say the same thing. My sister Ourania—or Rani as we call her—was diagnosed with late-stage kidney disease less than three years ago. That disease very quickly progressed to total kidney failure within a few months. At the time she was told her life expectancy would be two years at the most. Rani spent her fiftieth birthday in hospital, and soon after she was transferred to a nursing home, where she continues to receive long-term palliative care. She is bedridden and has lost total use of her legs. She is prone to both infection and wild fluctuations in her insulin levels, which lead to frequent ambulance trips from her nursing home to the hospital for urgent treatment. She is no longer the bubbly young girl full of life, the champion sprinter, the doting aunt or the person who always optimistically saw life as a glass half full. However, through the high-quality care she receives, she tells us that she is not in actual pain and, in fact, on many days she says that she feels quite well physically. But mentally there are days when she is depressed and other days when she is completely demoralised. Her ability or desire to speak or even to stay awake fluctuates with her mental state. On her better days, her old optimistic nature surfaces and she dreams of the day in the near future when rapid advances in medical science may cure her disease and help her to return to her previous life. We all pray that her dreams are realised. Through Rani's ordeal over the past few years I have realised that although diagnosis of disease is excellent, predictions of length of life for those living with a terminal illness are simply guesses rather than scientific estimates. I have also learnt that good-quality palliative care is not just a last-few-days treatment option. In fact, if it is provided early and in conjunction with other treatment, it can both relieve pain and significantly enhance quality of life for extended lengths of time. The biggest barriers to good quality palliative care are cost and availability, which I will address later.

In my previous working life as a legal practitioner, I was exposed to the legal and ethical dilemmas around determining mental capacity of a client to execute important legal documents such as wills, enduring powers of attorney and documents relating to health directives that would be enforceable either after the person had lost capacity or, in the case of a will, after they had died. There was never a hard and fast test, and practitioners had to

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rely on a combination of guidance notes, court precedent and experience. Good file notes were absolutely critical in such situations. To avoid the potential for future challenges, there were a number of occasions when I asked a client to provide me with a medical certificate stating that they had the capacity to give instructions and execute a document. In these types of cases, the issue of capacity was usually mingled with a concern about coercion or undue influence. That was magnified when the client was sitting in my office and being assisted in providing instructions by a relative—usually an adult child. We know that in many cases the capacity of a person to execute the document at the time of execution or the voluntary nature of their actions have been questioned in court action either after the person has lost capacity or after they have died. Often in such contested cases, the eventual decision by the court has found that the person did not have the capacity to execute the document they made. As I stated earlier, the complex threshold issue of capacity is often intertwined with the even more complex issue of voluntariness, which involves the consideration of whether a person is acting under some form of coercion, duress or other external influence. Sometimes such influences are subtle, especially when the person is in a vulnerable stage of their life or when they are at the early, and often undiagnosed, stages of losing capacity for one reason or another. What to a legal or medical practitioner may be seen as a voluntary decision may not be seen as voluntary if the person's full circumstances were known. As we find out more about elder abuse, we learn just how subtle but equally strong these pernicious outside influences can be in certain cases.

Since debate on this legislation commenced in earnest, like everyone else in this place, I have made sure that I take very seriously the views of the public, especially voters in my electorate. Amongst my constituents from the Hillarys electorate who have contacted me expressing their opinion on this issue, many have shared some very personal and very moving stories. I thank each and every one of those local people for sharing their stories and their views with me. A few constituents have simply wanted clarification about the legislation; however, the vast majority have been strong advocates on either one side or the other of the debate. Unlike some of the published figures and experiences of other members, my constituents are split absolutely 50–50 for and against this legislation.

As someone who takes their role as a legislator seriously, I have always had a strong sense of where the threshold lies between fair and appropriate legislation that promotes the common good of society and legislation that overreaches into areas that are not the appropriate realm of government. To that end, I have always drawn the line at legislation by which the state interferes with human life itself. It is why I have always opposed the death penalty for serious criminal offenders, despite proudly being someone who is tough on criminals and will always stand up for the rights of victims of crime. It is my belief that the state has no ethical or moral right to sanction the taking of a human life. I take this same ethical position in relation to the bill before us today.

I want to make it very clear that although I am a religious person, this is a position that I take not on religious grounds, but rather on my philosophical belief in the appropriate role of government and the appropriate limits of legislative power. As former Prime Minister Paul Keating put it so eloquently on similar legislation in the state of Victoria —

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

In my opinion, legislation to permit assisted dying crosses that threshold and goes beyond the norms and values of our society. It is not legislation that I can support.

However, I do recognise that others do not hold that view and that in our democratic society and in a democratic Parliament like ours, the majority view will prevail. That is why, as a legislator who takes my role in creating good, safe and ethical legislation seriously, I would like to take some time to point out what I consider to be serious and fundamental flaws with this bill. I do so in the spirit of cooperation, in the hope that the government will at the very least accept that suggested improvements to the legislation will create a less dangerous framework than the one contained in the bill before the house.

My first concern is a fundamental one about the protection of vulnerable people. I have concerns that there is no adequate provision contained in the bill to unequivocally ensure that a person has the capacity to make any decision to end their life.

**The ACTING SPEAKER (Mr I.C. Blayney):** Excuse me, member. Ministers, I am having trouble hearing the speaker because of your conversation. Thank you.

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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**Mr P.A. KATSAMBANIS:** There are a number of protections that could be considered to ensure that people are making a voluntary decision to end their life with full decision-making capacity and free of any coercion or other pernicious external influence. The first such protection should be the need for some form of formal psychiatric assessment of the person by a qualified professional. I spoke earlier of the type of demoralisation terminally ill patients, including my own sister, can feel. This can cloud their judgment and often render them incapable of having the capacity to make this type of decision. As the Chief Psychiatrist of Western Australia recommended in his submission to the Joint Select Committee on End of Life Choices, any legislation regarding assisted suicide must ensure an extremely robust assessment of capacity and screening for mental illness. The Chief Psychiatrist further submitted that psychiatrists are the people who are appropriately qualified to assess such capacity. We need to heed this advice from the state's Chief Psychiatrist. Failure to do so runs the risk that people without the proper capacity to make such a decision can be taken advantage of and killed. We have seen how capacity decisions made in the context of the execution of wills and other legal documents have later been found to be wrong. Sadly, in a jurisdiction such as the one we are contemplating, such findings after the event would be far too late.

After determining capacity and a voluntary decision, the next serious issue that presents itself is the issue of diagnosing a terminal illness. There is no requirement in the legislation that the certifying doctor has any specialised knowledge of the condition or illness that is being diagnosed. Nor is there any need for the doctor to have had any prior knowledge of the medical history of the person concerned. One would think that these matters would be threshold tests, but they are not covered in any way in the legislation. Apart from giving rise to concerns about doctor shopping by vulnerable individuals, it raises concerns about ethical medical practice.

[Member's time extended.]

**Mr P.A. KATSAMBANIS:** It may sound far-fetched to some that an orthopaedic surgeon could sign off that someone has cancer. However, I was reliably informed at a briefing by Professor David Kissane that this actually happened in the Northern Territory when it had similar legislation in place. Actual knowledge of the patient and their medical history is also important in eliminating any risk of coercion or other undue influence. It is unfair and, frankly, unconscionable to ask a doctor with no such prior knowledge of the patient and their history to make a determination on someone's capacity to decide to end their own life.

Unlike the Victorian legislation, the bill before this house does not prohibit a doctor from initiating the discussion about the subject of assisted dying with a patient. I see this as another fundamental protection for vulnerable people, many of whom, for cultural or other reasons, may be strongly influenced by any suggestion made to them by a medical practitioner.

Another threshold issue that needs to be addressed is the lack of appropriate palliative care in Western Australia. As I stated earlier, my sister has an ongoing need for such care. As a result, my family knows firsthand how good palliative care can alleviate pain and significantly improve quality of life not just for a few days—as is the common misconception—but also for an extended period of time. We also know how limited the availability of such care is and how expensive it can be.

Palliative care is less than ideal in Western Australia. You do not have to ask me; you can ask anyone. It is of course worse in the regions, but the availability of palliative care is in crisis even in the metropolitan area. Demand certainly outstrips supply in the northern suburbs, including in the electorate of Hillarys. Yes, the government has provided some additional funding, which is welcomed by all. However, as the Member for Girrawheen pointed out in her contribution, the reality is that the claimed additional resources are only partly new funds and are partly repurposed funds. Even then, not all the claimed funds are actually being allocated to palliative care. Palliative Care Australia has determined that the appropriate ratio for palliative care specialists in our community is two per 100 000 people, which means that we need around 50 such specialists to be in a position to provide appropriate palliative care across this state. That is even before taking into account the extreme geographical and remoteness challenges that we face here and that other states of Australia do not face. However, we currently have only 15 such palliative care specialists in WA, across both the public and private systems. Unless and until we close the palliative care gap we will simply not be providing appropriate care choices for people who are seeking to relieve excruciating pain, especially towards the end of life. The sad reality is that without adequate funding and a proper commitment to investing in palliative care, if this bill becomes law in our state, in many parts of Western Australia assisted dying may sadly become the only available choice for relief of pain for terminally ill people. If it happened, that would be a humanitarian travesty of the highest order.

I share the concerns that have been expressed to me by many medical practitioners that the legislation as currently drafted would cause them significant ethical and moral issues, especially with regard to their adherence to medical ethics and the Hippocratic oath. Many doctors who do not want to participate in any regime of assisted dying would

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like to simply say to any patients who raise the subject, “This is not an area that I practise in”. In fact, in discussions with two very senior medical practitioners in the past week, I have discovered that many doctors are under the misapprehension that they would be able to do just this under the proposed legislation. After all, recommendation 20 of the report of the Joint Standing Committee on End of Life Choice clearly states —

The Minister for Health should ensure that health professionals are not compelled to participate if any voluntary assisted dying framework is developed for Western Australia.

Sadly, that is not the case with the legislation before us today. In fact, any doctor who does not want to address this issue with a patient and refuses a request for assisted dying is compelled to follow the proposed statutory framework and provide the patient with information that is approved by the CEO, in whatever form eventually gets approved, and we have not seen that as yet. A practitioner who fails to comply would be liable to a penalty of \$10 000. Doctors who have a genuine conscientious or ethical objection to this regime should not be compelled to take any action at all beyond simply advising the patient that they do not engage in such practices. This would not only implement the recommendations of the joint standing committee, but would also alleviate the legitimate concerns and the ethical dilemma of many hardworking and committed medical practitioners.

The bill permits the use of audiovisual means of communicating requests for voluntary assisted dying. This brings the legislation into direct conflict with the provisions of section 474 of the commonwealth Criminal Code Act. This would potentially subject medical practitioners using audiovisual means to criminal penalties under commonwealth law. It may also make these specific provisions, or even the entire bill, subject to constitutional challenge. This is not an idle threat; this is real. Before the Victorian legislation came into operation earlier this year, Victoria’s health minister, Jenny Mikakos, issued a warning to doctors registered to discuss assisted dying with patients to meet all patients face-to-face to avoid potentially breaching commonwealth law. I know Jenny Mikakos—she is a good legal practitioner, prior to becoming a member of Parliament—and I know she would not issue such a warning without sound legal advice. It is something we should heed here in this state as well. This issue certainly needs to be properly addressed to ensure that medical practitioners are not inadvertently exposed to commonwealth criminal penalties. There are many other issues that need to be addressed to ensure better protection for both patients and practitioners. Time does not permit me to raise them all now but I am certain these issues will be covered in consideration in detail by many members on both sides of the house. I trust the government will address these issues in good faith.

In closing, I would like to add my own thanks to everyone who has participated in this debate both in the public realm and in this chamber. We are dealing with a very emotive issue of conscience and serious importance. Debate has been conducted respectfully and fair consideration has been given to divergent viewpoints. It is a testament to our maturity as a Parliament and as a society that we can hold these debates without recourse to threats, abuse, violence or marginalisation. As the debate progresses through the Parliament I trust that everyone will continue to remain respectful and tolerant of all points of view that are legitimately raised in debate. If this legislation does become law in Western Australia, I sincerely and honestly hope that it will give comfort to those who seek relief without unfairly impacting on vulnerable people and without it becoming a default pain relief option in the absence of appropriate palliative care. I also hope that the minister will accept the suggestions for stronger protections that have been made in good faith by me and by other members of the house, including many who support the principles of the bill. However, I affirm my support for the sanctity of human life and my conscientious belief that the legislation before us today crosses the threshold beyond which Parliament should not venture. Thank you.

**MR V.A. CATANIA (North West Central)** [5.26 pm]: I will not take long on this. Members have been approaching the Voluntary Assisted Dying Bill 2019 through their own personal experience, or through being members of Parliament. This legislation should not be supported just because, as reported in the newspaper, 88 per cent of Western Australians support voluntary assisted dying, or it is promoted as being popular. We should ensure that, as members of Parliament, we look at the legislation brought before this house and consider it in detail to ensure that it is as watertight as possible, and also consider all the unintended consequences, which a few members have brought up. That is our role in this house—not to do what is popular, but to make sure that legislation is as tight as possible.

The questions I have to ask myself about this bill are: Do we wish to give the terminally ill, who are in pain, the choice to end their suffering? Is it about life, or is it about death? Is it about how the death will occur? Is it about freedom of choice for individuals to make their own decisions about their own lives, and to have the decisions made for them? Last, but not least, I am a Catholic. Should I just say no, because of my religious belief? I have watched three grandparents pass away in pain, while receiving palliative care to make that pain go away to some degree, or, as far as we know, make that pain go away. This legislation would not protect them. It would not assist them in passing in an easier way. I have seen terminally ill people, and I have seen that with my mother-in-law, who suffered from pancreatic cancer, much like the husband of the Leader of the Opposition. She was diagnosed

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in 2014, and in her last days she obviously tried to do everything to prolong her life, even as far as me going out to the bush to collect bush medicine, to make that bush tea to assist in reducing the size of the cancer in the pancreas. Unfortunately, the illness got the better of her, and in the last seven days of her life she was lying in bed motionless, with the morphine being increased as each day went by.

In that instance, I asked my ex-wife what her mother would have liked to have done—would she have considered voluntary assisted dying if she had that choice? The answer was yes; if she had that choice, she would have considered it. My mother-in-law was in pain, and lying motionless. She knew that death was imminent—it was going to happen. That was difficult for not only my mother-in-law, but also for the people around her. Is that the way in which people with a terminal illness should die? That is the obvious question in my mind. All of us in this place have to decide whether voluntary assisted dying is a humane and safe way for a person to end their life, knowing that death is imminent. My father-in-law passed away from terminal lung cancer, and, although his death was quick, I saw the suffering that he went through. Unfortunately, the discussion about whether he would have signed up to voluntary assisted dying if he had been given that chance was never had.

On Father's Day, we had a gathering with my father and other family members. After dinner, we had a debate about voluntary assisted dying. My father is a Catholic. His religious beliefs do not permit him to support the legislation. He strongly opposes the bill, as members on the other side would know. We had a debate about whether we should support the legislation, particularly given the fact that a few members of our family have had a terminal illness and we had seen the pain and suffering they went through. The debate started to get a bit heated, and I am smart enough not to take on my father in a debate, so I started to pull away and end the debate —

**Mrs M.H. Roberts:** Times have changed!

**Mr V.A. CATANIA:** Times have changed! That is right.

**Mr P.A. Katsambanis:** I think it's called maturity!

**Mr V.A. CATANIA:** Maturity! That is right.

Another family member has a terminal illness—mesothelioma. That is not widely known, because they have not told many people. This person got involved in the debate and said, "I've got mesothelioma, and I would like to be able to make the decision to end my life when I believe it is necessary to do so." It silenced pretty much everyone around the table to be faced with a family member who is going through that. The Leader of the Opposition clearly put forward the thoughts of individuals when they go through that process. I do not think anyone wants to die. Everyone wants to hang on. Everyone wants to see their kids grow up. Everyone wants to be with their family members for as long as they can, and that is what we should try to achieve. However, that becomes difficult, knowing that death is imminent and staring you in the face. Sometimes people have the will to live, but they know that time is against them.

No-one wants to see suffering occur. My wife is a veterinarian, and she sees death happen quite often. We put animals down, in a humane way, knowing that it is very difficult for animals to get around if they are in pain and are suffering. Obviously, my wife is a strong supporter of voluntary assisted dying. A photo of every animal she has had to put down is on the photo board of her vet clinic. Every time my wife has to put an animal down, it is hard.

I have had this discussion with many people around the electorate of North West Central. Can I say that the feedback from people who have approached me on this issue has not been that great. I have chosen to bring up voluntary assisted dying at every individual meeting and every group discussion I have, just to see what people's thoughts are. I do not ask whether they support it. I let people tell me what their thoughts and concerns are. As I said at the start, I believe that a lot of people think that this bill will enable our seniors and grandparents to access voluntary assisted dying. The common feedback I get is that if a person is 92 years of age, bedridden, weighs only 30 kilograms and things are not looking too good for them, they would like to be able to end their life with a bit of dignity. That is taking it to the next level. I do not know that I could support legislation that would allow that to occur. Generally, in a group of 20 people, five are very vocal and very supportive of the legislation, and the rest have concerns or questions, because they do not know much about it. As has been said in this chamber during this debate, there is obviously a group of people who do not support voluntary assisted dying, for various reasons. However, all in all, there is strong support—to a degree—in the community of the north west. That may be because of the harshness of the environment. People in the north west go through a lot of hardship. Sometimes people take their own life with their own firearm. I am sure the member for Kalgoorlie came across a few situations during his time as a police officer when people just wanted to end their life. A lot of the suicides in regional Western Australia, particularly in the north west, occur because people in the bush often have access to weapons.

In my opinion, the support in my electorate for this legislation is close to 50–50. People are generally supportive. However, they want to ensure that safeguards are in place. The members for Girrawheen and Hillarys articulated

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some of those concerns that need to be addressed and will be fleshed out during the consideration in detail stage in this place. One thing that causes concern and has been highlighted—I think the member for Warren—Blackwood said it perfectly—is that we cannot have voluntary assisted dying and palliative care as one. They are two separate issues. The debate on voluntary assisted dying does highlight the need for greater services and funds in palliative care. Correct me if I am wrong, Minister for Health, but I do not think any palliative care exists in regional Western Australia, particularly in the north west of Western Australia. What concerns me, and I think the member for Girrawheen pointed this out, is that it is about old money and new money. One issue that has been close to me and my electorate has been that of Carnarvon aged care. When the Labor Party came to government in 2017, \$5.5 million was taken out of the funds for building a 38-bed aged-care facility. But now that \$5.5 million has been put back into the budget to complete the 38-bed aged care facility under the auspice of palliative care. In my mind, that is not new money. That money is there to complete the 38-bed aged-care facility for Carnarvon. I am glad it will have palliative care attached to it, because not having palliative care in places such as Carnarvon is becoming a growing issue. That is replicated pretty much throughout regional Western Australia. Palliative care needs to be addressed and funded to ensure that people have those options. As the member for Hillarys pointed out, we do not want voluntary assisted dying to become the norm. We do not want that becoming the only option—a default position. We do not want that becoming the only option that one has. We do not want people to have to move from the place that they were born and lived the majority of their life—that is, a regional town. I will use Carnarvon as an example. We have seen when seniors have to be moved out because there is no aged-care facility in Carnarvon, and they have to go to Perth or Geraldton. Unfortunately, their lives are shortened. Allowing people to die with dignity in their own home or town needs to be addressed by this government and future governments, because this is not an issue that will diminish over time.

In terms of this bill, I liked the words of the Premier, and I would like to quote him.

**Mrs M.H. Roberts:** That is a first!

**Mr V.A. CATANIA:** I will clarify it. Let me finish it off.

[Member's time extended.]

**Mr V.A. CATANIA:** The Premier said —

It is a freedom of choice for individuals to make their own decisions about their own lives and to not have decisions made for them.

I agree. I hope that the Premier can look at other legislation for issues, such as organ donation as another example. People can choose to be an organ donor but when they unfortunately pass away in an accident, the family or relatives have the final say over the person's wishes. I take it that the Premier's words about the choice for individuals to make their own decisions should extend to organ donation. Let us make sure that we have legislation that not only assists people who are terminally ill to pass away with dignity to ensure that their pain and suffering is minimal, but also lets us give life to those people who need an organ to survive, whether it be a young kid who has cystic fibrosis or someone who needs a heart or kidney transplant. Let us give people their choice to assist others with organ donation, not a family member who will not adhere to their wishes and who will say no to organs being donated. Members, and Premier—if you are listening—I take the words that the Premier said about this bill and I hope that they can be replicated in a future bill in which we see opt-out legislation and organ donation being front and centre to make sure that those individual's wishes are adhered to so that we can also assist people to live into the future.

During the consideration in detail stage, I will ensure that we try to tighten up this legislation, because there are some genuine concerns. Whether or not members agree with this legislation, this is our opportunity to tighten up this legislation so that we can do what I believe is right and support voluntary assisted dying for the terminally ill. I am sure that we all want that choice. Let us hope that we do not have to make that choice in the future, but I know that we have family members who will go through it, and I hope that this legislation is passed so that they may be able to make that decision or at least have that choice in the future. I have to support that person's wishes to support this bill, even though we need to go through it in detail to make it as tight as possible. It is the right thing to do to make sure that when people are terminally ill, they have that choice to end their life with dignity, with less pain and suffering for not only them, but also their family members. I support voluntary assisted dying.

**MR K.M. O'DONNELL (Kalgoorlie)** [5.47 pm]: Greetings, Acting Speaker! I, too, wish to talk on the Voluntary Assisted Dying Bill 2019. In my very first speech, the very first comment I made to the Speaker was that I feel more comfortable in a pub brawl than standing here. Nothing has changed—fair dinkum. I would rather come up against bikies and violent members of our community than stand up and talk a lot. I have watched our

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other members. I was not here last week; I was in Dowerin, but I watched and listened to various members, and it has been a very heart-wrenching debate. The member for North West Central said that he is a Roman Catholic. I, too, am Roman Catholic, a proud Waverley College boy and Aquinian.

I have received numerous emails both for and against voluntary assisted dying. Some were based on religious reasons and others were cut and pasted. I say to people out there: do not cut and paste. That is my opinion. Tell me what you think. If people can keep it short and sharp, it makes it easier. Sometimes I have had emails that I have had to scroll through page after page after page. It would be very helpful if there were bullet points and it was not cut and pasted. I enjoyed reading various individual ones. Many who said that they were against voluntary assisted dying made comments about how their loved one died peacefully in palliative care. I thoroughly agreed. An example states —

1. My stepfather had a stroke ... he was moved to a care institution ... where he died peacefully some time later.

He died peacefully.

A mother was diagnosed with a quick-acting cancer and given a month or two to live. She was transferred to a nearby hospital with a palliative care facility and given the best of care and comfort until she died about a month later. The person commented that they had the greatest of respect for these institutions. Another person was diagnosed with liver cancer and given some months to live. She expressed the desire to remain at home, where she was looked after by family, who kept her comfortable and properly medicated until she died peacefully at home. What I noticed in a lot of the anti-voluntary assisted dying correspondence was the fact that people's loved ones died peacefully. I did not get any correspondence from people saying that they were against voluntary assisted dying and that their partner or their loved one was in excruciating pain for months—that it was a debilitating disease and they were fading away, having to wear a nappy and suffering so much. We are all different, but I do not think I could stand by and watch a loved one in excruciating pain. If they had the option to take up voluntary assisted dying to end the pain, I could understand them taking it. We talk about family pets. We take our dog, cat or horse to the vet and the vet says that the pet is in excruciating pain and will not have much time to live. Do we then say that we will take the pet home and keep it in excruciating pain? The vet gives an option and my belief is that everybody would take the option to put the pet out of its misery so that there is no pain, because most people regard a pet as a part of the family. Another lady was given 15 months to two years to live. She was given the choice of a risky operation, but she opted for palliative care. She was transferred to Murdoch hospital. She was looked after and spent time connecting with family until she died peacefully in her sleep a week later. Again, I say that every one of the emails I got that were anti-voluntary assisted dying said that the family member died peacefully; none of them said that the family member had pain or anything.

I attended a briefing with Andrew Denton. It was in the Legislative Assembly meeting room. I sat down there and looked around. The member for Morley was speaking and was about to introduce Andrew Denton. I kept looking around and I thought I had made a mistake and had the wrong time, date and place, because the other 30 people in the room were all Labor and there were no Liberals. I thought, "Oh!" I put my hand up to ask the member for Morley whether I could be excused, but I was informed that the briefing was open to every member of Parliament. I must admit that I was made to feel welcome, but I was surrounded by red. I was completely outnumbered, member for Baldivis! Andrew Denton made me feel welcome as well. I rated him after meeting him. I listened to what he said and it hit home with me, and I enjoyed it. On the flipside, I went to the anti-voluntary assisted dying briefing with Dr Cheng, a lovely lady, and she gave a very compelling story. I also had the opportunity to meet Belinda Teh. I think many of us have met her. She is a wonderful lady who walked across Australia. I met her and her fiancé and we sat and talked for about one hour and a half on a Saturday; it was great. I will tell members how impressed I was. I was looking to hire somebody at that stage and I spoke to my other girl and said, "Geez, if Belinda lived in Kalgoorlie-Boulder, I would offer her a job in a heartbeat."

**Mr R.H. Cook:** If she lived in our electorates, she would probably be taking our jobs. Be careful what you wish for!

**Mr K.M. O'DONNELL:** Yes!

**Dr M.D. Nahan:** She might go walkabout on you!

**Mr K.M. O'DONNELL:** Yes, she might go on the next expedition; we would have to control that!

I was very impressed with her. I listened to her story about her mother, who was a very strong, staunch Roman Catholic. We have heard the story, but her mother was in so much pain prior to her death. She was a staunch Roman Catholic against voluntary assisted dying, but she said that she could not take the pain any longer. We did not have this legislation, and Belinda's mother went through all this pain and debilitation before she died. That is going to be

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etched in Belinda's mind forever and a day. I felt sorry for Belinda when she told her story. However, I was very impressed with her. Belinda actually changed my thinking.

Members are not considering voluntary assisted dying instead of palliative care. As the member for North West Central said, they are two different things; however, they do go hand in hand. We should consider showing compassion to people for whom palliative care does not relieve suffering. Palliative care cannot relieve every person's pain and suffering; however, it does a damn good job. The member for Carine mentioned an article by Nathan Hondros on WAtoday on 28 August 2019. It refers to an alarming lack of resources available for palliative care, especially in the regions. That was disappointing. The article says —

... palliative care specialists have said no Western Australian would die in pain if the state allocated adequate funding to specialist care.

I thoroughly disagree with that comment. After listening to the debate on this bill, I have no doubt that in the years to come, whether the government is Labor or Liberal, palliative care will go ahead in leaps and bounds in order to ensure quality of life for people. I am not a university-trained person, but I cannot see how anybody could say —

**Mrs M.H. Roberts:** You have got police training; that is more important!

**Mr K.M. O'DONNELL:** I thank the minister. Correct, I do have training.

I am sorry, but I cannot wear that people say that no Western Australian would die in pain if more money was thrown at palliative care—but still keep throwing money at it, minister. It was disappointing to read that only one in three Western Australians who need specialist palliative care have access to it. That was a bit disappointing. The article referred to late referrals to voluntary assisted dying. Another doctor said that palliative care cannot relieve everyone's distress, which is correct. The article said that around one per cent of people have severe and unremitting terrible distress and pain.

A lady named Angela Miller wrote a letter to the *Kalgoorlie Miner*. She was replying to one of our revered local reverends, Dr Elizabeth Smith, who had written an article against voluntary assisted dying. Angela had to have her say, not in a derogatory way, but in a very polite way. Angela said that her father had passed away. Palliative care uses drugs to take away the pain, but her father was allergic to morphine, and morphine is a popular drug used by doctors to assist in the relief of pain. The only option available was to keep him asleep. She was referring to the fact that if pain medicine does not work—in this case, the morphine could not have—something else will be tried, and if that does not work, a third option is tried. If that still does not work, deep sedation is used. In other words, the patient is placed into a drug-induced coma. The family and friends are around a loved one and the only way the person's pain can be taken away is for them to be put into a drug-induced coma. When people come to visit, the person is unconscious. Some family members think that at least they have their loved one with them.

*Sitting suspended from 6.00 to 7.00 pm*

**Mr K.M. O'DONNELL:** Greetings, Acting Speaker. I will continue by saying that this bill is about providing assistance to someone who is dying—not euthanasia and not suicide. I agree with this. I attended plenty of suicides in my time as a police officer. I came across hangings, shotgun deaths, poisonings and drownings. People commit suicide for various reasons, such as financial issues, domestic arguments or ill-health. In my 34-odd years as a police officer, I also attended when people had died in hospital, and I had no doubt at different times, even when I was not the inquiring officer but simply attended the scene, that the person was helped along the way. I have no doubt and firmly believe that over years gone by, whether decades or centuries, we have had voluntary assisted dying. On one occasion, I asked whether the family member wanted to give me a statement. They said no, and I know why they said no: the doctor helped that person, alleviated their pain, and they passed on. I got no comment then. I dare say that many other police officers have come across the same thing, and I do not believe it is just here in Western Australia; I would say that it is worldwide.

There is a requirement in the bill for patients to make a written submission. I have a query about that. In my dealings with the mob from the desert, I have come across people who cannot read or write. I first came across that when I asked somebody to sign. I put an X where to sign, and they put an X. I said, "No, you've got to sign." The X was their signature. I was quite young when I came across that. Even 10 or 20 years later, the same thing still happens—they put an X. I hope there is a provision to help or deal with the mob who cannot read or write. There might be some wetjala—white people—with the same problem. There could even be some Europeans, because a lot of elderly people move here with their family as refugees, so there may be an issue there; I do not know. Hopefully, that will be addressed.

I have a query about independent doctors.

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]

p6276b-6341a

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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[Member's time extended.]

**Mr K.M. O'DONNELL:** The legislation states that assessments must be conducted by two independent registered practitioners. Both medical practitioners must independently come to the view that the patient satisfies all the eligibility criteria. My query is: if someone approaches a doctor and says, "I want to access voluntary assisted dying. Will you assist me?", does that doctor then go back and ask for all the information from the general practitioner, or do they independently and separately do tests and make inquiries? I am curious about whether that makes it independent, rather than both practitioners getting the same information.

Moving along, it was disappointing to hear that the goldfields receives only 12 visits a year from palliative care specialists, with visits only once a month to Kalgoorlie. That is disappointing. Hopefully, in the years to come, that will be rectified. I took a tour of the Kalgoorlie Health Campus again the other day. I was walking through a ward. All of a sudden, I crossed over a line of vinyl on the floor to carpet. It had a completely different feel. They said, "We're in the palliative care unit." Kalgoorlie has a three-bedroom unit. Even though it is about nine or 10 years old, I was very impressed with the rooms. My idea of palliative care is that it is for the elderly—somebody like the member for Pilbara or the member for Bunbury!—older statesmen. It is for people who are ready to be moved on from their seat. I do not mean that in a derogatory way!

**Mr R.H. Cook:** You are digging deeper, member!

**Mr K.M. O'DONNELL:** Yes, I apologise. While I was there, I fell over when they were talking about a four-year-old girl in the palliative care unit in Kalgoorlie recently. You could have blown me over with a feather. I have seen a lot of things and done a lot of things, but a four-year-old kid in palliative care was sad. They said that they would like to try to get a room done up to make it a kids' room, because they do not have one in the children's ward. They were also talking about Aboriginals in palliative care. Minister, I have a question; hopefully, I will not double up. I am hoping there has been consultation with the mobs from various communities out in the desert around payback. Payback in Aboriginal culture can be very strange to us. I came across a group of Aboriginals who had borrowed a car from a bloke out at Coonana. They drove it into town, rolled it, and one man was killed. We expected the person to get payback would be the driver who had borrowed the car. No, he did not get speared; the owner of the car got speared. He should not have lent the car in the first place. Sometimes we do not understand the thinking, but I have been told by people in the goldfields that there could be an issue with Aboriginals accessing voluntary assisted dying, in that somebody is helping that person to die rather than that person dying the natural way. More than likely, they will not go after the doctor or the nurse; it will be the family member and/or friend who has guided that person there. I am not saying that that will happen; I am just making members aware that that has been brought to my attention under the issue of Aboriginal payback. We can never stop payback—it has been in the Aboriginal culture for centuries—but that could be an issue down the track.

The other day I asked Amelda, the palliative care specialist at Kalgoorlie Health Campus, how many patients she sees. She said that she has 98 on her book. "No!", I said. I congratulate the hospital on this; it allows Amelda to work with Bega Garnbirringu Health Service, the Aboriginal group, and to go to local nursing homes and other hospitals in the region, including in Esperance. The hospital pays for her, but she goes everywhere and deals with all these people. After finding out about it, I think she does a fantastic job.

I have a query about death certificates. In all my policing career, when police turned up to a death and a doctor said that they would issue a death certificate, half the time police would rub their hands with glee because the paperwork would stop and they would not be bogged for hours, days or weeks. I assume that the two independent doctors—if they are not one of the family GPs—will have sufficient information because they have agreed to the voluntary assisted dying and that would be sufficient to sign a death certificate.

**Mr R.H. Cook:** Yes.

**Mr K.M. O'DONNELL:** Yes. I have talked about clause 14(c).

I just want to say that I love life. For me, I would rather live through the suffering—it is easy to say—so that I can continue to see my loved ones, including my three fantastic grandchildren. The fourth grandchild is coming this month, when Precious has her first child. And I still want to keep watching Collingwood. They are the things that I love and I would rather push through the pain barrier, but I do understand that some people do not have a very good pain threshold. I can understand. I can stand here and say that I will do it, but I might not. For me, I do not want to go down the path of voluntary assisted dying. I do not. I want to stay alive as long as I can and see every day. That is what I want to do. I know I am not as suave looking as the member for Dawesville as I get older, but I want to stay alive. I do not want to participate in voluntary assisted dying, even though I support voluntary assisted dying. I can understand it for those who have a low threshold of pain. None of us wants to see people suffering.

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]

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May I ask a couple of questions in this debate?

**Mr R.H. Cook:** If you want me to interject and if I am in a position to answer them, sure.

**Mr K.M. O'DONNELL:** If the minister knows straight up, I do not mind. If not, we can leave them to a later time. This question is probably too hard, but what strategies does the government have in place in remote areas? My thinking is about being remote, because of where I am. What will the government do for those wanting to pursue voluntary assisted dying in remote areas so that it is an equal playing field with those residing in the metropolitan areas? In Perth we have doctors, nurses and video communication aplenty. Out in the remote areas, it is just dirt roads, as members would know, and some people live in places with no mobile access, so I do not know whether they can get internet access and such things. That would be one of my questions.

**Mr R.H. Cook:** As you would know, the package that we have announced as part of the budget is predominantly focused on making sure that we have better palliative care services in the regions and that is one of the elements that the Department of Health is grappling with at the moment. I am not going to lie to you, though. We will never be able to make health services in the remote communities like they are for people in the metropolitan area, but I think we can do better.

**Mr K.M. O'DONNELL:** I appreciate that. I thank the minister. I raise that issue because we struggle to get doctors and nurses in remote areas. It is very hard. I am not sure how we can do it and I am not belittling this, but if we can try to get more police officers dating and marrying nurses, when the copper transfers, he will bring the nurse with him.

**Mrs L.M. Harvey:** It works with schoolteachers.

**Mr K.M. O'DONNELL:** A schoolteacher—yes.

**Dr D.J. Honey:** With him or her.

**Mr K.M. O'DONNELL:** Yes, it could be either.

**Mr R.H. Cook:** We have the rural clinical schools. They have been outstandingly successful. One of the elements of that is if we get young doctors out in the communities who invariably meet young members of that community, they stay in that community to both practise medicine and start a family.

**Mr K.M. O'DONNELL:** I just have to finish up. I refer to life insurance companies. I was not here last week. Someone might have touched on that, but, hopefully, there has been consultation with them so that people are not disadvantaged. There is nothing worse. They are not going to get paid out. They just have to put up with months of suffering. I will support this legislation. I am looking forward to the consideration in detail stage. There are probably some other aspects to clarify. Minister, I wish you good luck with it at the consideration in detail stage.

**MRS A.K. HAYDEN (Darling Range) [7.15 pm]:** I thank my colleague for a great contribution. We should have had him last week when we had a few full-on emotional speeches; it would have been a nice interlude.

I rise to oppose the Voluntary Assisted Dying Bill 2019. In doing so, I acknowledge that this is an extremely difficult and emotional debate and I have no doubt each member has spent many hours and days, if not weeks, contemplating the ramifications of this legislation. This bill will be one of the most important and challenging pieces of legislation that will ever be debated by many of us in this place and it has been reflected through every member having the right to vote as per their personal conscience rather than party aligned, although as a Liberal, I always have that ability. This legislation highlights the importance of this right. In our role, we are posed with many challenges, some far easier than others, and this debate would have been one of the hardest challenges I believe members will ever face. Even if members know their position, the time spent digging deeper into the decision is extremely emotional, personal and sometimes conflicting. The discussions we have with family, friends and people within our own electorate on this topic delve deeper than most conversations we usually have with one another, the most difficult being when opinions differ. After 10 years of experience as a member of Parliament, I have learnt the need to respect one another and even though our opinions might not align, it is important to let people voice their opinion without fear or favour so that members can rise and give their thoughts without unwanted interjection or adverse commentary. I acknowledge the many members who have shared their thoughts so openly and bravely. I know it has been tough for quite a few.

The community conversation is an important one. I know from the many conversations I have had on this bill that the original off-the-cuff position on this important subject by many often changed after we started discussing the reality of this legislation, especially when we discussed the possibility of error, influence or abuse that could occur. Another concern that swayed first impressions of this legislation was who would be responsible for administering the substance to take another's life. This question had people admitting they could never do it. People understand that

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it is a difficult ask of our doctors, who have dedicated their career to protecting life. The option of self-administration was also raised as a concern, with the idea that people may be asked to aid, or need to have the aid of, a loved one, which I believe will occur in some circumstances regardless of it being legal. The idea of having to go through this experience was not warmly welcomed and it was agreed that it would have a long-lasting effect on those involved assisting in taking a life. The directions of the conversations I had changed the more that we discussed the reality of assisted dying. I have had many people finish the conversation with me by saying, "I would hate to be in your shoes" followed with comments along the lines of, "I haven't really given it that much thought before. I am glad it's you having to make this decision and not me." After speaking with people who were adamantly supportive of euthanasia, I saw them shift. They now had doubts and concerns. It may be easy to get a poll to support assisted dying in principle, but when we ask questions and they understand the consequences and ramifications of this bill, doubt enters people's minds. We do not have capital punishment in our country for the same reason. We cannot rule out the possibility that a person who has been sentenced to death and then killed may later be found to be not guilty. There is an element of doubt. I believe that there is an element of doubt in this legislation as well.

As members of Parliament, we are elected on the values and principles we advocate to our communities in the lead-up to election day. We are not elected on just the promises we make or the party that we represent. Many people take time to learn more about us as people to understand the principles that will underpin the decisions that we will make if elected. During the Darling Range by-election, I was questioned on this topic and others. Those discussions continued as I engaged with my community. All members of Parliament have a choice—a chance to stand on our convictions, to let them be known and to have the conversations. I choose to stand on my convictions. I believe that the Australian public look for that in their members of Parliament.

These principles guide our moral compass and determine who we are as individuals, what we will stand for, and what we will not tolerate. We need to show strength and leadership and not be sheep, but, rather, to stand up and be heard. We should not be afraid to ask the difficult questions or fear the ramifications that may follow if we do not follow suit. Unlike most members in this chamber, I have already had this debate and undergone the soul-searching process required to make such an important decision. In 2010, my second year in the upper house, Hon Robin Chapple tabled the Voluntary Euthanasia Bill. When asked during the recent election campaign in 2018, I declared my opposition to euthanasia and highlighted the need to invest in palliative care and ensure that every Western Australian, no matter where they live, can access the support provided by palliative care. I outlined that position during my campaign and will honour my commitment to those who put their faith in me on election day. I will stand by my convictions.

Palliative care is poorly understood by many in the community, including healthcare workers. We should not be surprised, because a conversation about dying is not one that we often have around dinner tables. It is not one of the top 10 topics with which to start a conversation. The reluctance to discuss death at any point has resulted in a misunderstanding of palliative care. A majority of people would say that it helps to ease pain in the last few hours of life; in fact, it is far more than that. Palliative care is available from the moment a person is diagnosed with an illness with no existing cure, and it is available while people undergo medical treatment. The service aims to provide people with the best quality of life, no matter how long their life is. It can be days, weeks, months or even years. There is a misconception that palliative care is only for the last few days, and that it occurs only in a hospice. Palliative care includes counselling and grief support for both the patient and their family members. The main service is to relieve pain and the other symptoms of the illness such as vomiting, shortness of breath and depression, but palliative care also provides access to resources such as equipment needed to aid care at home, improving the experience and quality of life, and extending a person's life. It assists families to come together to talk and discuss sensitive issues. It connects the patient and the family to other services such as home help and financial support. It assists people with cultural needs and provides emotional, social and spiritual support for people who feel depressed, emotional or alone, which can often lead to some individuals believing they would rather go now than later. Pain is not always physical; it can also be emotional—a lack of sense of worth, embarrassment or a sense of being a burden. When assistance is provided, equipment obtained and emotional support given, life can be improved and, in fact, cherished. Without this help, some people may feel that their life is pointless.

However, 60 per cent of Western Australians are unable to access or are unaware of palliative care services that are or should be available to them. About 160 000 people die per annum in Australia, and about 40 000 of them receive palliative care. About 14 000 people die per annum in Western Australia, but it is unclear how many of them receive palliative care versus how many could benefit from it but are unable to access it. Professor Kathy Eager, director of the Australian Health Services Research Institute at the University of Wollongong, stated that 40 per cent of Western Australians who could benefit from palliative care are currently receiving it. That means that 60 per cent of Western Australians who could benefit from palliative care are not receiving it. By comparison, Palliative Care Victoria stated that one in four—10 000—Victorians miss out on palliative care.

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I have been advised that across Western Australia, there are only 15 full-time palliative care specialists and that Royal Perth Hospital provides specialist palliative care only during office hours. Western Australia has the lowest number of publicly funded care beds per capita in the nation. In the current budget, the state government has spent \$12 million on palliative care in regional WA. The University of Notre Dame's chair of palliative medicine research, David Kissane, said that the state needs to spend an extra \$100 million a year on palliative care on top of the additional \$40 million that has been budgeted for the next four years.

I struggle to understand how we can be willing to legislate for euthanasia before first attempting to provide palliative care services to all. More than 80 per cent of deaths are due to five causes, which can generally be predicted, so those people can benefit from palliative care. Surely, we owe it to our community and the 80 per cent of people who would benefit from palliative care, and to the regional communities that either cannot access this care service or are simply unaware of it, to deliver that care service before we offer them a solution to end their lives.

In September 2018, the state government welcomed the report tabled by the Select Committee into Elder Abuse, titled "'I never thought it would happen to me': When trust is broken". I will not go through the entire report today, but the committee identified the very sad statistic that up to 75 000 older people are at risk of elder abuse in Western Australia and that previous data estimated that between two per cent and 10 per cent of older Australians will suffer from elder abuse. The report highlighted that most of this abuse comes from within the victim's own family circle. This report uses the words and terms intimidation, bullying, coercion and threatening behaviour to describe the abuse that elders in our state are currently suffering. The media statement of 13 September 2018 by the Minister for Seniors and Ageing and the Attorney General states —

The State Government has welcomed the tabling of the Select Committee into Elder Abuse report as it continues to develop and progress policy in response to the emerging issue.

The statement continued with the Minister for Seniors and Ageing acknowledging —

Elder abuse is an emerging issue and the Select Committee report is an important resource ...

Although the government acknowledged the recommendations of the committee and the need for legislation to be introduced to combat the growing incidence of elder abuse in WA, 12 months since its media release and the tabling of the committee report, we have not seen any new legislation addressing this extremely important concern. I understand that it takes time to get legislation of this importance correct, but I do not understand how we can be discussing legislation that will end a life when we have not addressed the very concerns raised in the elder abuse report. The concern is that we could see the vulnerable within our community bullied and coerced or intimidated into a state in which they feel worthless, which could influence their decision to end their life. Legislation to combat elder abuse and to safeguard one of the most vulnerable groups within our community should have been in place before this legislation was introduced. Again, we are discussing the introduction of a bill that will take a life, yet we have not addressed the growing emergence of elder abuse and the lack of access to palliative care.

I refer to the poison that will be used. The Western Australian government has yet to outline what substance will be administered. I have concerns that we are debating legislation without all the details. Not knowing what substance will be used to kill another human being is a real issue and one that I am struggling with. Let us call it what it is; it is poison. The term "substance" is used throughout the bill. Why is it not simply referred to as per the description in the bill—that is, poison. The explanatory memorandum states —

**Clause 7 Voluntary assisted dying substance**

This clause defines *voluntary assisted dying substance* to mean a Schedule 4 or Schedule 8 poison, approved by the CEO under the *Voluntary Assisted Dying Act*, in order to cause a person's death.

The terms Schedule 4 poison and Schedule 8 poison are defined in section 3 of the *Medicines and Poisons Act 2014*.

How can we be expected to support legislation that will take another human's life without knowing what the poison will be or how it will work? What guarantee do we have that it will work effectively and without pain? We cannot, and just guessing and assuming is simply not good enough. I understand that authorities in Victoria have refused to release the details of the poison, or drug, used in its voluntary assisted dying program to avoid copycats, but it is believed to be similar to pentobarbitone, also known by the brand name Nembutal. It is a short-acting barbiturate that causes death by respiratory arrest. It is used in veterinary clinics in small doses as a sedative and in high doses to euthanase animals. An oral dosage of the drug is used for assisted death in Oregon, Washington, Vermont and California. A solution of pentobarbital sodium and sugar syrup in a 20 per cent ethanol solution is used in the Netherlands. The same drug was adopted by some states of the US to execute criminals following reports of failed executions. However, some lethal injections using pentobarbital have also been reported to have failed. A local

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US paper reported on failed executions on three occasions. Without going into the detail, because I do not believe it is necessary for us to do so, I think it is vitally important for us to understand this reality—it cannot be ignored. The failed attempts were not pleasant and were referred to as alarming, with the victims in distress. How can we be expected to support legislation that could deliver the opposite of the intent of its supporters in this chamber? We cannot be confident or guarantee that this legislation will provide a dignified and peaceful death, yet most speakers have used those words in support of this bill. There are cases in which this drug has not delivered a peaceful, painless death. Not knowing the substance the government will decide on using is simply not good enough.

What has become obvious over recent years is that the people of Australia, and particularly Western Australia, are seeking, as I said earlier, conviction, honesty and strength from their members of Parliament. I have replied to all within my electorate who wrote to me on this issue, and I thank them for sharing their views with me. I outlined my position to them. I have to say that the number of inquiries to my office was extremely small.

During this debate, statements have been made that it is not a euthanasia bill and that it is not assisted suicide; however, the definition of “euthanasia” is the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma. The definition of “assisted suicide” is suicide effected with the assistance of another person, especially the taking of lethal drugs, provided by a doctor for the purpose, by a patient suffering from a terminal illness or incurable condition. The definition of “assisted dying”, which is the term used in this bill, is that it is a practice whereby a person suffering from a terminal illness or incurable condition is helped to take their own life, especially by means of lethal drugs provided by a doctor for the purpose. Again, I do not understand the arguments that have been put during this debate that this is not a euthanasia bill, nor is this assisted suicide. This bill will enable someone to take their life and to allow another to assist. No matter what the title of this bill, it is suicide and it is euthanasia, so why are we denying that, why is it not being discussed and why is it being hidden?

[Member’s time extended.]

**Mrs A.K. HAYDEN:** As I have outlined, the argument that this bill will provide for a peaceful and dignified death is an argument that I really struggle with. As a reminder, our parliamentary role is to review, debate and pass legislation to form law. In doing this, we are to ensure that the legislation passed is the best it possibly can be or not pass it at all. In order to do this, we need to understand the detail and investigate every clause of the bill to ensure that there are no unintended consequences and that no-one is left vulnerable or at risk as a result of the legislation passing. Along with the concerns I have raised about palliative care and elder abuse is my concern about the lack of information on the substance that will be used to act out this assisted dying, as I have already outlined. This is where I would like the minister’s response. If the information is not available to us, how can we know or ensure that death will be painless and with dignity, and how can we possibly know how death will take place? We have no knowledge of the chemical component that will be used under this legislation—legislation that we will be voting on. With any other bill, we would be demanding full disclosure of all this information, yet this is just going through without any comment. Included in this legislation is the choice to self-administer at home. My concern is with how we, as legislators, can be confident that this will not be open to abuse or misuse.

I want to walk members through scenarios that have been keeping me awake at night—scenarios that could easily play out with the passing of this legislation. For example, an eligible patient is granted the right to take their life and they choose to self-administer and to die at home. A number of paths could be taken and a number of paths could occur. The first is that they follow the instructions and succeed in taking their life. The second is that, for a number of reasons, including medical, they cannot swallow or their digestive system is not working and they are unable to digest the entire contents of the drug and do not succeed. The third is that they share the drug with their loving partner, who wishes to pass with them. Let us talk through that third scenario. What if I were diagnosed with a terminal illness and I wished to take my life, so I choose to take the substance home and die at home. My husband chooses to go with me—he does not want to continue life without me and wants us to leave together. Now, a number of paths could follow. Sadly, both could pass—one healthy, one not healthy. A second path is that neither could be successful, because they have shared the poison they have been given and it is not enough to take both their lives. The third is that the dying partner passes but the loving partner survives. Going through all that trauma—I cannot imagine it. The fourth is more unlikely but still possible: a dying patient survives, because they simply cannot swallow or digest the drug, but the loving partner does not. I simply cannot vote for this legislation knowing that that is a possibility. It is on us to make sure there is no possibility that scenarios such as this could ever happen. We are here to protect our community. I am confident to say that I do not believe anyone involved in this debate would view any of these scenarios as acceptable. I am also confident to say that these scenarios are not the intent of this bill. However, the real issue is that these four scenarios could happen on the passing of this bill, and that is what scares me.

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One other issue I wish to raise is the cost, which is also not outlined in the bill. Who will be paying for this? Will there be a government subsidy? Will it be listed on the pharmaceutical benefits scheme? If not, I go back to: how much will it cost? I have heard figures of around \$5 000. I have also been told that in the US, the cost ranges from \$8 000 to \$11 000. If this is a rough estimate of what it will cost to access assisted suicide, I suspect that it will be out of reach for many in our community. Again, we have no detail on this matter, nor could I find it addressed in any of the reports that were the basis for this legislation. I hope the minister will be able to answer these questions. What will it cost to access euthanasia? Who will pay for it? If it is the government, how much will it cost the state? Is funding allocated; and, if so, where and under which portfolio? If it is to be funded by the individual, how much will it be and who will be paid?

I go back to the concern that I and many others have raised during the debate around the lack of access to our palliative care services. Remote and vulnerable members of our community already struggle to access palliative care because the state is unable to allocate enough funds to extend the service and people cannot afford to travel to receive it. I am interested to hear from the minister: if the government is funding people to access euthanasia, why has this been made a priority over extending palliative care and protecting our elders against abuse? At best, whether or not you support euthanasia, this legislation is premature. It is inappropriate for WA to be contemplating voluntary assisted dying when the report of the Joint Select Committee on End of Life Choices confirmed that there are serious deficiencies in palliative care across our state—deficiencies that are still waiting to be addressed. It is also inappropriate for WA to contemplate voluntary assisted dying when the report of the Select Committee into Elder Abuse unanimously found that we have a serious elder abuse problem in WA, and this is also waiting to be addressed. It is also inappropriate for Western Australia to be contemplating voluntary assisted dying when it is far too early for us to assess whether the new Victorian legislation is safe. To me, it seems silly not to wait and see how it plays out in Victoria, before we make the same mistakes. It takes only one life to be lost in error, one life to be lost as a result of abuse or one attempt to fail or to be taken in extreme discomfort—it does not matter how many safeguards we put in place, they will not be sufficient. For that and the other reasons I have outlined, I will not be supporting this bill. I will seek the minister's answers to some of the questions I have raised during this speech during the consideration in detail stage.

**MR R.S. LOVE (Moore)** [7.40 pm]: In starting my contribution tonight, I understand that this is an extremely sensitive issue and, for some people, a traumatic one. No person's life is the same and no person's death is the same. People's experiences of this issue are different. There are many different points of view about the Voluntary Assisted Dying Bill 2019 and its nuances. I appreciate that. I stand very reluctantly to talk about this issue. It is not an issue on which I would seek to deliberate. It is a weighty issue and not one that I approach without a sense of trepidation. All of us have our own lives. None of us want our lives to end in an unpleasant manner and none of us want to see the people we care for suffer.

In beginning this contribution, I recognise the efforts of all those involved in the extensive consideration of these issues. First, there are the people involved in the Joint Select Committee on End of Life Choices, including the committee staff, who are the unsung heroes in these types of deliberations. They sit through the same evidence that members sit through but they then have to sift through that in some detail and so they live it much more deeply than do members. The members of the committee that was formed to investigate this matter performed their task diligently. I know that many of them were personally affected by some of the stories they heard. I recognise the efforts of the chair, the member for Morley; the deputy chair, Hon Colin Holt, who is a member of my party; the member for South Perth, who I think I saw in the gallery a little while ago; the member for Mount Lawley; the member for Baldivis; Hon Robin Chapple; Hon Dr Sally Talbot; and Hon Nick Goiran, who delivered a minority report, "The safe approach to End of Life Choices: License to Care not Licence to Kill". It was a detailed contribution from that single member and is testament to his mental and intellectual acumen. I also acknowledge the contribution of the Ministerial Expert Panel on Voluntary Assisted Dying: the chair, Mr Malcolm McCusker, AC, QC, an eminent Western Australian who, I think, has the respect of everybody in the chamber; the deputy chair, Dr Penny Flett, AO; and all the other panel members. I acknowledge the community members who contributed to the investigations and consultations of both the committee and the expert panel. I respect and recognise the good intent and integrity of all those involved.

There is little doubt that the weight of public opinion—and, I think, the overwhelming number of members in this house—is firmly in support of the introduction of a form of voluntary assisted dying in Western Australia. That being said, it is the duty of every member, no matter how popular an issue, to carefully weigh the issues relating to all legislation. I have done that. I have consulted with my community but not, I might add, as extensively as did the member for Dawesville, who personally contacted 6 500 people and asked them their views, but within the limited ability that I have as a member of Parliament. I have come to the view that most people with whom I have spoken are

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in favour of voluntary assisted dying. Some of them had very passionate views because of their personal experience. I say to all those people that none of their views are discounted in anything that I will say from now on. I had to weigh up not only their views, but also what I think is right. That onerous decision and duty has been placed on all of us. Having done that, I have come to the view that I do not support the bill. In doing so, I do not cast a negative view on any member of this house who supports the bill or has a contrary view on this matter because all of us have done our best to weigh up community representation, our personal experiences and the experiences that others have relayed to us in coming to decisions on this matter. I expect that, given the number of those members in the house who have expressed support for the bill, it will quite easily pass in this house. Although I will not vote in favour of the bill, I will attempt to contribute thoughtfully to the consideration in detail and point out any improvements that I think can be made. I was told by government members last week that the government will not entertain any amendments during consideration in detail. If that is so, that is disappointing. It should be recognised that no legislation is necessarily perfect when it comes to this place and improvements should be considered when they are pointed out. Fortunately, we have a two-chamber Parliament and I can only hope and assume that more consideration will be given to improvements to the bill in the Legislative Council, our house of review. I am sure that the Council will discharge its duties thoroughly, with the possibility perhaps of a committee examining the legislation thoroughly.

I know the government has to organise its business throughout its term, but one of the things I find a little hard to understand is the tight timetable of all of this, including the scope with which the ministerial expert panel was allowed to examine issues. I know, having spoken to people involved in health, that drafts of the bill were circulated early on, well before the select committee had met. I think there is a level of pressure to get this done within a certain timetable and that is disappointing because it is a hugely important bill. If any bill needs and deserves the full examination of both chambers, it is this bill. It should not in any way be short-circuited. I hope that the Council looks at this bill thoroughly.

Having had discussions with community members and, indeed, at the ministerial expert panel consultation round table that I attended in Joondalup—unfortunately, I missed the one in Geraldton, which is close to my electorate, because I had to attend another event, but I went to Joondalup with the view that some people in the south of my electorate may well be in that area and I did recognise a couple of people—there is a strong view that voluntary assisted dying is required. Having had discussions about many circumstances, it seems that palliative care is felt not to be sufficient to relieve the suffering of a portion of those who are dying from a terminal illness. That may or may not be so. It appears to be at odds with some of the palliative care practitioners with whom I have had the occasion to discuss these matters. It appears that often palliative care is sought far too late, when there are just weeks left of a person's life. In briefings and discussions, palliative care specialists have expressed the view that palliative care should be more deeply embedded in the medical system and that part of the problem is the view amongst some of the, shall we say, go-getters in the medical world, the active can-do guys who are doing the surgery, that they do not need to involve palliative care until they run out of options. From what I understand, that is not the way it should be run and it is not the way to get the best outcomes for patients. In fact, I think that was borne out in finding 12 of the Joint Select Committee on End of Life Choices' majority report, "My Life, My Choice". It states —

Access to specialist palliative care in the early stages of a diagnosis might improve remaining quality of life, mood, resilience, symptom management and allow for death in the patient's preferred location. These benefits would be more readily available to patients if difficult discussions about death and dying took place earlier.

I think that is the core of it. Some of the medical professionals are not ready to accept that the patient is terminal or that death is inevitable—well, death is always inevitable, but that death is inevitable at a predictable rate and the patient is beyond the point where treatment will be effective in prolonging life. It is a matter of trying to embed much more deeply in the medical profession the idea that, even if a disease inevitably claims a patient's life, if we can extend their life and their quality of life, that is a desirable outcome, so the two things work hand-in-hand. I think there is a bit of, shall we say, tension between those two aspects.

This is particularly concerning for regional people, which is borne out in findings 19 and 20 of the report, which spell out something of a warning for regional people. 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 Services.

As a regional member of Parliament, I find that particularly concerning. I have said in this house before that I would not like to see people accepting voluntary assisted dying simply because they are unable to access proper palliative care in their own region or community. I have said that on a number of occasions and other members of

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the Nationals WA have also highlighted that as an issue. Although this is a matter of conscience for National Party members and we have different views on these things, I also think there are some commonalities in that we all recognise that regional people should not be disadvantaged in their access to palliative care, and even though I do not support voluntary assisted dying, if it is going to be available, it should be available to everybody equally. The Leader of the National Party earlier outlined some of the issues around the ability to access all sorts of medical services as part of this legislation, and that needs to be addressed. Both the minority report by Hon Nick Goiran and the majority report pointed out those deficiencies.

I refer to a media release this month by Dr Anil Tandon, chair of the Western Australian Palliative Medicine Specialist Group, in which he points out that —

“WA has the fewest number of palliative care specialists per capita, —

Presumably in Australia —

the lowest number of publicly-funded palliative care beds, and only one-in-three people who could benefit from specialist palliative care has access to the services they need.

That points out that there is a very big gap in the whole system. This is also borne out in an article by Nathan Hondros from 28 August, “‘West Australians should not ponder euthanasia due to lack of care’: End of life specialists”, which again points out the lack of palliative care as an issue in Western Australia generally. The member for Scarborough, the Leader of the Opposition, also pointed out that there were issues in the metropolitan area. We are concerned that regional areas are a focus for improvement, but in fact, as the Leader of the Opposition has pointed out, there are gaps in the metropolitan area as well. We should not be blinded to the fact that this is a statewide problem.

**Mrs L.M. Harvey:** It's a significant issue.

**Mr R.S. LOVE:** There is a significant gap, and in fact the same article states —

The University of Notre Dame's Chair of Palliative Medicine Research David Kissane said the state needed an extra \$100 million a year spent on palliative care.

This is on top of the extra \$40 million for palliative care over four years announced by the government in the state budget.

It is easy to pluck figures; the government has plucked a figure of \$40 million and applied it to palliative care; it might fix it up, but Dr Kissane is saying, “Well, another \$100 million might fix it up”. I think we need some proper planning, to set out some parameters, work out just how much it will cost, and then action that as quickly as possible. Just plucking a few figures out of air sounds good; \$40 million sounds like a lot of money. It might be a drop in the ocean compared with what is required, or it might be more than sufficient. I do not know, but I do not think there are any real parameters around any of this at the moment, and that in itself is very concerning.

The member for North West Central made his contribution just before the dinner break and he pointed out the need for aged care in Carnarvon. He understands that the \$5 million that went towards that is not really going to address the statewide need for palliative care. Good on him for his advocacy, and I applaud him for the effort he went through on behalf of the Carnarvon community to get that aged care facility and to make palliative care available in his town, but a lot of other towns need to be addressed as well, and they cannot all have facilities unless we are going to put a lot more than \$40 million into them. It is time for the government to take this very seriously. I know that statements were made by the Minister for Health and the member for Morley during the matter of public interest, but we certainly need to take this very seriously. I reiterate what I have said before on this matter: I do not want voluntary assisted dying to become the default choice for regional people simply because they have no access to decent palliative care. I see the member for Kimberley; I am sure that in the Kimberley there are many examples of people being unable to access that level of care.

[Member's time extended.]

**Mr R.S. LOVE:** I do not believe that we should be considering the introduction of voluntary assisted dying until our palliative care is brought up to scratch. Others might disagree with me, and that is fine; we are all entitled to an opinion.

I turn now to the whole idea of the slippery slope argument, and it is real. We are told that the Voluntary Assisted Dying Bill 2019 has adequate and extensive safeguards—one hundred and something has been quoted—and some of them are not so much safeguards as procedural matters, but nonetheless, there are a number of safeguards in this bill. If we examine the Victorian legislation closely we see that there are some differences, and the differences seem to be a freeing-up of some of the Victorian safeguards. An analysis in *The Australian* of last weekend, 31 August, points this out, as well as discussing the draft Queensland bill, which has been floating around and which widens even further some of those processes. For example, the Western Australian bill allows doctors to suggest voluntary

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assisted dying, whereas the Victorian legislation does not; in fact, it precludes it. The Victorian legislation requires a medical specialist to be involved in the assessment of a patient; the Western Australian bill does not. The Western Australian bill will allow more active participation by medical people in actually administering the lethal drugs. In Victoria, a doctor who is unwilling to participate in the process can simply refuse to; in Western Australia, they are required to pass on general information, which will actually involve them in the process. Whichever way we look at it, they will actually become involved in the process of that person moving towards voluntary assisted dying.

When we have six states all bringing in different legislation and all looking at the legislation that the other states have brought in, and they all bring in legislation just a bit more liberal than the previous legislation, we are going to end up with a far more liberal outcome at the end than what Victoria first envisaged. That is because there are no absolute lines in any of this. Once we cross that line and allow voluntary assisted dying, everything else is pretty much subjective. Once upon a time we used to have absolutes in our society such as, “I believe in God and the principle that was outlined in a document handed down to Moses 5 000 years ago”, but now most people do not hold that central to their belief systems. When we move from that into a system in which people determine their own measures, it is much easier to see how this “creep” of scope of something like voluntary assisted dying will occur. That is something Paul Keating pointed out in his opinion piece that was published in 2017, when he said —

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.

I fear that, in the future, pressure will come on more and more to broaden the scope and the eligibility of voluntary assisted dying in areas such as its availability to people with mental health problems, its availability to people who have an illness without a predictable life expectancy, its availability to children, and its availability to people suffering from dementia, perhaps using advance medical directives. We should note that the Attorney General here in this house proclaimed last week that the Western Australian government will not be accepting recommendation 23 of the final report of the Ministerial Expert Panel on Advance Health Directives. Recommendation 23 stated —

If, at a future point, voluntary assisted dying legislation is implemented in Western Australia, the State Government could consider establishing an Expert Panel to provide advice and recommendations on how to provide people with a neurodegenerative condition access to choice regarding voluntary assisted dying, in particular through the potential application of advance directives.

The Attorney General and the Western Australian government will not accept this, but in fact the ministerial expert panel has put it on public notice as an issue. It will be a live issue.

A week or so ago, *The West Australian* published a survey that showed 88 per cent of people support voluntary assisted dying. That strong level of support has been cited by a number of people as a reason for them changing their views on this issue. Public pressure and public opinion makes a difference. I suggest that the people I have spoken to would support the use of voluntary assisted dying in the case of dementia. A lot of them support it. How many of the 88 per cent would actually support that? Does anyone in this house seriously believe that the public does not support voluntary assisted dying following an advance health directive? I do not believe that for a minute. The same people who came to me and said, “We believe voluntary assisted dying should be available”, want that for the people who end up with dementia. Many of us live in fear of dementia. In fact, representatives from Dementia Australia were here in Parliament a week or so ago. The member for Girrawheen and others were at their presentation. I have here with me a copy of a fact sheet that was spoken about. It says the leading cause of death in women in Australia now are conditions related to dementia. The second leading cause of death in Australian men are conditions related to dementia. Given the recognition of the ministerial expert panel and given the disappointment my constituents feel when I tell them that dementia will not be covered by the Voluntary Assisted Dying Bill—because it is assumed there is a lack of capacity for people to access it—I am sure at some point the push will be on to extend the eligibility. Bear in mind Paul Keating’s words, “Once the threshold is crossed, it will be much easier to liberalise.”

On the question of capacity, we have to imagine the capacity of a 40-year-old person in full health who is sitting around talking to his wife and kids and everyone else, or the husband and kids and whomever it is, about their future, who has a greater mental capacity to make those decisions than a person who is suffering from a terminal illness, who is receiving medications and treatments that are grossly affecting their ability to function, and they are facing an existential threat to their existence. In those circumstances, I believe that person is not in exactly as good a position mentally to make those decisions as we are right now to make decisions about what should happen to us in 40 years’ time, should we have dementia. I believe that the 88 per cent of people who support voluntary assisted dying would also support that proposition. Once these things are added, the list will only continue to grow.

What about the availability to children? Why is the suffering of a 14-year-old not considered as important or any less real or less distressing than the suffering of a 40-year-old? There was a case in the UK—the member for Hillarys

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would have heard of it—the Gillick case, in which the House of Lords established a principle that young people have a right to determine their medical treatment. That has been supported in cases in the High Court of Australia. Those principles were outlined and accepted in Marion's case. Why does this bill not reflect that legal principle? Why are the rights of a child to seek that same sort of medical intervention not being respected in this case when they are in other cases? I go back to the point: why is the suffering of a 14-year-old or a four-year-old any less real than the suffering of a 40-year-old? This bill has been written by adults about adults, but what about the kids? Kids also die from horrible diseases.

As soon as we accept this legislation, these very difficult issues will have to be addressed. It is all very well to look at the examples. I know adults who have suffered terribly—I have great sympathy for them; I would not like anyone to suffer—but we have to accept that once we move into this field, a whole range of other parameters need to be addressed. Constant pressure will be on to address each and every one of them if we move into that field. That was examined somewhat by the Joint Select Committee on End of Life Choices. I will read from Hon Nick Goiran's minority report. In doing so, I pay tribute to the work that he did in this area. He was talking to Philip Nitschke, who is a bit of a doyen amongst those people who believe in voluntary assisted dying. I will read a few examples. According to page 230 of the report, Dr Nitschke stated —

*What has happened where we have seen laws change... such as places like Holland, where I am now a resident, is that over the years people realised that the onerous restrictions cause difficulty and, of course, there is an erosion or a change to those requirements. We have seen changes here, first of all, to the age of eligibility, and then the nature of the condition and the nature of suffering that entitles a victim to make use of these laws.*

Dr Nitschke went on to say —

*... the question is now: is it a right or not for an elderly person to simply say, "If I want these drugs, I should be provided with them?" In other words, we are seeing a change from it being considered not just as a medical privilege for the seriously ill who qualify, but as a basic human right.*

...

*I want to see a debate held about a "tired of life" argument such as we are seeing here in the Netherlands. Should every person over a certain age be issued with those drugs? That is where the debate will go. I am predicting that. It will happen even in Western Australia and other Australian states, because that is where the debate around the world is heading.*

Again, these things have a habit of changing. The pressure comes on for the whole gamut of the legislation to grow.

I will finish by reading once again from the minority report. I refer to a quote from Fabian Stahle's "Moral Disengagement — Mechanisms Propelling the Euthanasia/PAS Movement" published in the *Journal of Ethics in Mental Health*. The quote in the report states —

*Voltaire has said that those who can make you believe absurdities, can make you commit atrocities. The first absurdity may be to claim, against better knowledge, that it is possible to construct a safe system for the medical termination of people's lives. Once that absurdity has been elevated to truth status, you and those you have seduced into agreeing, can actually end up supporting an activity that you initially felt was abhorrent—now with hardly any regrets at all. The abominable thing has thus been normalized or even glorified. Black has become white.*

**MR P. PAPALIA (Warnbro — Minister for Tourism)** [8.09 pm]: At the outset, I would like to acknowledge the Minister for Health and the member for Morley for their roles in leading this debate in many respects and in leading the consultation across the state of Western Australia. While I am acknowledging people who have made a contribution, I would like to acknowledge the Ministerial Expert Panel on Voluntary Assisted Dying and its magnificent chair, who is a great Western Australian and has made a significant contribution here and throughout his entire life. Malcolm McCusker, AC, QC, should be acknowledged at this time. Whether or not people agree with the Voluntary Assisted Dying Bill 2019 and the concept of voluntary assisted dying, it is undeniable that a huge effort was made to consult with the community to seek out differing views and to ensure that those views were represented on the panel and that experts from the entire spectrum of views were given the opportunity to contribute to the discussion around the development of this legislation. That is undeniable. It was led by one of the greatest Western Australians of all time. I think that is a magnificent contribution, regardless of people's views.

With regard to my contribution, I do not intend to delay the debate too long. I believe it is my obligation, noting that it is a conscience vote, to place on the record for the benefit of my constituents how I intend to vote. I intend to support this legislation. In making that statement, I acknowledge that a significant proportion of people within

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my electorate would not agree with this legislation and would prefer that I vote against it. To them I say: I cannot say that I understand your views, but I acknowledge them; I do not agree with your views, but I appreciate those of you who have made the effort to contact my office and notify me of your views. Invariably, those people who have contacted me who oppose the legislation do so because of religious conviction. In response to that I would say that they benefit from living in a secular state where the rule of law dictates people's freedoms. We are fortunate to live in a nation where we have separation of church and state. Religious zealots do not dictate what government should do. We have the opportunity for democracy to be exercised and, as a consequence, the right to practise religion is recognised and defended, and I will defend that right any day. I am proud to say that I have served the nation in a lot of different fields and I am proud that this nation is essentially secular. That means that every religion is defended and every religious person is given the opportunity to practise that religion, but it does not mean that religion can dictate what others must do. It does not enable adherents of a particular faith to deem others less worthy, it does not enable those who have a belief in God to suggest that those who do not believe in God are any less worthy as citizens, and it does not enable those people to dictate how anyone else should live their lives. The rule of law does that. The rule of law protects us all. I thank you.

I recognise that many people will be disappointed by my intention to vote in support of this bill, but I believe it is about choice. This legislation will provide some people with a choice, but not as many as the community would prefer. It has nowhere near the extent of reach that many people in the community would believe is reasonable. Nevertheless, it will provide some people with the option to choose the nature and time of their death, noting that they are facing impending death in the near term anyway.

The reason I support the bill, apart from my belief that it is the right thing to do, has been dictated by personal experience in recent times. In the first of two cases, both of which were very close to our family, within the last year, our family witnessed someone in palliative care. Despite those who oppose this bill and suggest that palliative care is an alternative to a death that does not have dignity and is painful—in some cases it may be—the experience I witnessed was that palliative care essentially deprives somebody of nutrients and fluids until such time as they weaken, their organs fail and, as that process carries on towards death, they are sedated so that they hopefully do not feel pain, and then subsequently pass when they are probably unconscious at a time essentially chosen, in many cases, by the doctor administering palliative care. That is what I witnessed in the delivery of palliative care.

**Mr J.E. McGrath:** That would be at a very late stage.

**Mr P. PAPALIA:** Correct. It is not an alternative to that process. It is not about someone's choice of the time of a pain-free and comfortable death to avoid the consequences of the body breaking down over time and, ultimately, the likelihood of not making a conscious decision about the time of their passing.

The other thing that occurred in recent months was the loss of a very close family friend to motor neurone disease. Palliative care does not make that disease a less horrible death. If people assume that it is a choice between palliative care and having a potentially very painful, frightening death that is lacking in dignity, it is not in all cases. It does not matter whether there is palliative care, confronting a death from motor neurone disease is not a nice prospect. The person is gradually deprived of their ability to conduct themselves in a normal fashion and to have any form of dignity. They know it is coming. They know what the symptoms are. They know that their capacity will be diminished over time. They know that they will lose the ability to control their movements and any form of bodily function and to conduct any of their own care over time towards an inevitable, pretty bad death. I can only say that providing someone in that situation with a choice is absolutely the right thing to do. This bill does not compel anyone to take the choice; it provides them with the alternative. While they are still capable, and despite knowing that they are confronting imminent death, they can choose the time. It is not a time chosen by the doctor who is administering the drugs and who is caring for someone who may be unconscious by the time they confront that end-of-life period, but a time they choose. We are enabling them that one decision while they are still strong enough to do it, while they are still coherent and have the cognitive capacity to do it, and while they are still able to say goodbye to their family and friends in a dignified fashion. I think that is the right thing to do.

Again, I commend those who have led this debate and those who have crafted the advice to government. I absolutely commend the legislation.

**MRS M.H. ROBERTS (Midland — Minister for Police)** [8.19 pm]: Euthanasia—this is not an easy subject. It has been an emotional debate for many. Many have related deeply personal experiences. There has been consideration of the death of loved ones and contemplation of one's own mortality; heartfelt emotions have been brought to the fore. I have received hundreds of pieces of correspondence, some for, others against this legislation. Each has been heartfelt and contains many very intimate accounts of the death of a loved one and many impassioned pleas about the consequences of the proposed legislation. I acknowledge those who have implored me to support

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the legislation; those who view euthanasia as a merciful compassionate choice—one each individual should be able to make for themselves. They ask: why should they not be able to make a voluntary choice to ask a doctor to end their life rather than endure the pain and suffering before an inevitable and relatively imminent death? I have thought long and hard about whether it would be right to support legislation to give them that choice. Some have been through incredibly harrowing experiences, and I am not immune from feeling the pain in their words or understanding their genuine plea. I have also read the equally impassioned pleas from those who see this as the thin edge of the wedge, or the slippery slope, as destroying the sanctity of human life, and who view the legislation as neither right nor good.

Most of what we do in this place is to affirm and support life. I have two portfolios—police and road safety—both of which are grounded in the common principle of safeguarding life. Indeed, the primacy of life is so important in the police portfolio that we no longer use death as a punishment, even for the most heinous of crimes. Instead, we feed, clothe and shelter them in line with international conventions. We do not have the death penalty, as has been mentioned by others. One reason we do not have the death penalty is that for some it is just a matter of the sanctity of human life; for others it is because they believe that it is far worse for one innocent person to be punished or to lose their life than it is for others to be set free. I find it interesting that people can have that consideration at that point in time: they would rather let people who have committed heinous crimes live than see a single innocent person face the death penalty—that finality—because mistakes can be and are made. Indeed, through the Innocence Project here and in the USA, in the UK and right around the world, DNA evidence has found that a lot of people who had been convicted of murder right around the world have subsequently been found to be not guilty. Therefore, we act with caution when it comes to people accused of crimes of that nature.

What this legislation is asking the Parliament to do is to reverse the common duty—to safeguard life. Some see this debate as being about the circumstances in which we can affirm death rather than the principle of whether we do so at all. This is illustrated by two key things—one, the elaborate mechanisms envisaged in the legislation to safeguard the process from coercion or abuse; and, two, the attitude of the medical profession. Much has been said already about the so-called safeguards, and I am sure much more will be said in the consideration in detail stage. The real point here is that we need them at all. The intention is to distance us from the reality of what we are doing. Their effect will be to legitimise and bureaucratise what is intended to be a pastoral process. The fact that we need safeguards means that there is something inherently worrying about the principle—there exists the very real opportunity for abuse. If we look to those safeguards, we will see the safeguards proposed in Western Australia are less than those in place in Victoria. A handy summary appeared in an article in *The Weekend Australian* dated 31 August, on page 18. It highlights a few of those differences and I itemise them here —

- Doctor can raise VAD with patient, reversing onus.
- VAD medication can be administered in some circumstances by a nurse practitioner.
- Self-administration remains preferred, but if the approving doctors agree this is inappropriate, physician-administered VAD allowed.
- No requirement for doctors to apply for a government permit in each case. No requirement for a specialist to be involved.
- If a doctor declines to participate on conscientious grounds, they must immediately inform patient and provide standardised information on accessing VAD.

These are all differences from Victoria's legislation. I acknowledge that not all doctors oppose this bill. However, the Australian Medical Association remains opposed. This should ring alarm bells for everyone. They are the very people who are closest to the issue on a daily basis. They are the best informed and they are the ones we expect to deliver the legislation. The fact that they are against it, or at the very least heavily divided, should concern us all. They are the ones who have the most experience in diagnosing terminal illness and conveying that diagnosis to patients. I fully understand that any doctor who opposes the legislation can opt out and will not be required to assist in euthanasing a patient, but that does not quell their legitimate and valid concerns—concerns that go well beyond the quality and availability of palliative care. They are concerned about the sanctity and preservation of human life; the potential for undue influence, no matter how subtle; and they are also concerned about the finality of any decision.

I have been there at the end of life for close relatives whose quality of life has deteriorated and who have been in their final days on earth. It is hard, but it is important. Indeed, it is a privilege to be there for those people. It can bring people together. It is about family, it is about relationships and it is important. I would not have had that experience any other way. None of us likes the thought of our children or their children suffering through seeing a parent wasting away or in pain, but in my view the alternative is worse. I am limited for time in these remarks

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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and will not elaborate, suffice to say that this has been more than eloquently explained by the member for Scarborough when dealing with her own personal experience. I am in no doubt that it was unbelievably difficult to see their husband and father waste away, but I am also in absolutely no doubt that it was much better than the alternative—and, in particular, so much better for the children both in the short term and the long term.

I am going to relate a situation that I was very closely involved in quite some years ago now. It is about someone who is known to people in this chamber. Batong Pham is a friend of mine. Just after his fortieth birthday, I think it was, one Sunday morning, he had a stroke. He had a wife, a child of about 18 months of age, and his wife was three or four months pregnant with their second child. Batong was taken to hospital—I think first to Joondalup and then to Royal Perth Hospital. He remained in an induced coma in Royal Perth Hospital in the intensive care unit for the remainder of that week. His was a Catholic Vietnamese family. They had come across perilous seas and settled in Perth, so they had already survived a lot. Here they were faced with this situation.

The doctors at Royal Perth Hospital told the family that Batong was effectively brain dead and that nothing was happening up there. By the Friday, his family were told that they should turn off the respirator and there was no hope for Batong because there was no brain activity whatsoever. The doctors showed them the various pieces of equipment and pointed out the normal range to indicate brain activity and a viable life. They showed that he was well below that; there was no activity and, therefore, no hope. Batong's family, being Catholic–Vietnamese, found it very difficult to deal with the concept of turning off the respirator and ending his life. His wife, who had gone up to the hospital on the Sunday, had collapsed in distress. She had had difficulty in earlier pregnancies and there was a lot of worry for her. She had been admitted to another area of the hospital for care and attention. Extended family of about 20 people or more remained outside the ICU praying the rosary and praying for Batong day and night for that whole week. But by the Friday, they said all hope was gone—no brain activity, no action—and that they should, on the advice of doctors, turn off the respirator.

As members will recall, the late John D'Orazio was a pharmacist. He was also a close and trusted friend of Batong and his family. John was also a Catholic. The family said to John, "The doctors are saying we must do this. We don't want to do it." Batong's parents did not understand it and his brothers and sisters and extended family did not support it. They trusted John to talk to the doctors on their behalf. They understood that he was someone with some medical expertise via his pharmacy degree. They knew that John understood these things and they trusted him. John talked to the doctors with the family about whether there was another way, because John said that if any healthy person were on the amount of drugs that Batong was on, they would not be able to breathe unassisted. They would need a respirator. John said that if the respirator was turned off, it was certain that Batong would die, because with the medication that he was on, he could not possibly sustain himself to breathe. John put a different proposal to the doctors. He said that perhaps they could accommodate the family's belief and our beliefs by reducing his medication and giving him the opportunity to sustain life himself, however unlikely that was. The family went along with that. They said, "Well, we will give that a go."

The doctors agreed to gradually withdraw the medication and said that in all likelihood he would pass away that evening or the next day—certainly within 24 hours or so. The family had a priest come and do the last rites. The family were all involved and said their goodbyes. John D'Orazio called me and explained what had occurred. I was at a function on the Friday night and had something to do on the Saturday morning, and he said, "Michelle, if you want to see him before he passes, you will need to come tonight." After I had been to the function, my husband and I went to Royal Perth ICU and Batong was lying there with his bare chest going up and down with the respirator. Two relatives remained there, one of whom was his brother. His brother sought the permission for us to go in and see Batong. I held his hand and I spoke to him for a very long time. After about half an hour, I felt that I was getting a response. I felt that he was responding to me talking to him.

My husband was sitting well over to one side, wondering how I could maintain a one-way conversation for half an hour with someone who for all intents and purposes looked as though they were already dead. Nonetheless, I did so. I held his hand and I talked to him about his wife Thuy, the young child Alban and the baby they were expecting. I talked to him about a lot of the good times we had had. Part of the reason I did this was that I had also had the experience of another friend of mine having Guillain-Barre syndrome—a locked-in syndrome—some years earlier and he told me that he had been laying in hospital unable to do anything or talk for months on end with his family visiting every day, initially talking to him and then talking across him. He said that was not too bad because he got to catch up on the family news. He fully recovered from his Guillain-Barre syndrome. It occurred to me that there might be a minuscule chance that Batong could hear what I was saying, so I was giving it a go. I felt that he was squeezing my hand at key moments. I asked him whether he could open his eyes. I saw his eyelashes move. He could not open his eyes, but I could see that he was trying to. I was starting to wonder whether it was my hope, rather than reality. His brother came over and looked at the equipment; he could see that the numbers had changed and things were happening. He ran and got medical staff.

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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[Member's time extended.]

**Mrs M.H. ROBERTS:** Before long, we had about half a dozen medical staff there who instructed me to keep talking to him. Batong had a tracheotomy so he had no opportunity to speak, but, to cut to the chase, within two or three days he was in a regular ward in Royal Perth Hospital. The doctors were unable to tell us whether he would be able to speak but it was clear that his brain function was there because he could hear and understand what we were saying to him. No-one should tell me that doctors do not make mistakes or that they know everything. If we had taken the doctors' advice and this family had not had the faith and made the choice to turn off his respirator, Batong would not have lived to see his second child born and his boys grow up. I know that in many other circumstances people get wrong diagnoses or medical advice.

Many in this debate have acknowledged the woefully inadequate availability of palliative care in this state, which our government is now seeking to address with a significant cash injection. There is still a long way to go before there are appropriate options for people in all different circumstances and areas of WA. Some have noted that the two states with the smallest per capita investment in palliative care are the same two states that have the highest percentage of community support for euthanasia, clearly implying that if more people and families had exposure to early and good palliative care, they would be less likely to see euthanasia as the solution. Some have said that they have polled their electorate and found a clear majority in favour. Some have looked to published polls that indicate a very high level of support for euthanasia. They have cited these as reasons that they will support the legislation. If those same MPs polled their electorates on capital or corporal punishment, I wonder whether they would feel the same obligation to go with the flow.

Some have risen in this debate to say that there is no right or wrong here, implying that it is just a difference of opinion, but then some have gone on to say that if we are compassionate and merciful, the only choice that we can make is to help people end their pain and suffering. I am not without compassion, nor do I want to see people suffer, but I really care about what is right and wrong. If this legislation passes, many people may well suffer tragic consequences—people who feel pressurised and vulnerable people who may have their lives cut short despite the repeated catchery of “it's voluntary” or “it's their choice”.

The very concern that I raise is countenanced in the bill. The so-called safeguards are testimony to that. They are there to mitigate against the prospect of someone being pressured. The question is: do they mitigate enough?

I read quite an informed article written by Peter Quinlan, who at the time was a barrister at Francis Burt Chambers, and published in *Brief* in November 2009. He set out the legal case for assisted dying. This article is opposed to the bill that was proposed in 2009. The arguments that he proselytises are just as valid today. The article is titled “Haggling Over Price: Euthanasia, Reason and Purpose of Law”. As people know, Peter Quinlan is an eminent solicitor. His introduction states —

“Would you sleep with me for \$1 million?”, Groucho asked the attractive young woman seated next to him at dinner.

Pretty woman, laughing: “Of course”.

Groucho: “How about for \$10?”

Pretty woman, aghast: “Mr Marx, what kind of girl do you think I am?”

Groucho: “We've already established what you are. Now we're just haggling over price.”

I will get back to that point in a moment. This is an eight-page article. I certainly do not have time to go through it all but I want to highlight some of the very salient legal points that Peter Quinlan has made. He states —

Firstly, the proponents of voluntary euthanasia clearly see their goal as directed towards a “Good”, in the classical philosophical sense of the term. Voluntary euthanasia legislation is, in this view, to be enacted because the right to euthanasia is a “good” or “right” thing properly to be desired. There is, accordingly, implicit in the voluntary euthanasia cause something objectively good, which goes beyond merely the desire of the particular applicant for euthanasia. What that “Good” is, remains to be explored.

The second way in which “natural law” concepts find their expression by the proponents of voluntary euthanasia is in the use of the concept of “rights”. Clearly, those who would legislate for voluntary euthanasia regard the applicant for euthanasia as having a “right” to intentionally terminate his or her life. I would also go further and posit that such proponents regard that “right” as being a “basic”, “fundamental” or “human” right. By this I mean that the proponent of euthanasia regards the “right to die” as inhering in human beings by reason of their status as human beings prior to those rights creation or recognition by the institutions of the state.

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I will miss a few paragraphs and go on to read some other valid parts of the argument. He lists some of the criteria for euthanasia, stating —

Without each of these criteria voluntary euthanasia is not to be permitted, even if it is desired (no matter how strongly or sincerely).

I note that his comments pertain to the 2009 legislation, not the current bill. He continues —

On what grounds is euthanasia to be made available to a person suffering pain as a result of an illness that will result in their death within ...

More importantly, why should the right to die be denied to a person who will never die of their illness or medical condition?

...

Clearly in relation to such persons, the “right to die” or their individual “autonomy” to determine the time, place and manner of their death is not to be accorded recognition (or respect) by the state. For those persons some other, unstated, consideration overrides their right to self-determination.

Effectively, he is saying that in some circumstances, people have a right. In some circumstances—specialised circumstances outlined in the legislation—people have a right to choose the time and place of their death but other people who do not meet that criteria do not have that right. That is the contradiction that he pointed to. He went on to say —

Necessarily then, something else is being “taught” by this law. And what is being “taught” and made abundantly clear, by this law is that, in some circumstances (that is, those contemplated by the objective criteria of the Bill) the Parliament (the expression of the community) agrees that “It is right and proper and reasonable, to regard nonexistence as preferable to this human life”. In other cases, however (those outside the objective criteria of the Bill), Parliament (the community) says, “No, this life has intrinsic value. It is worth living, regardless of whether the person who is living that life agrees”.

Immediately it is clear that what this law is teaching us is not something about “autonomy” or “individual rights” but something about the “value” or “worth” of the life in question. This is because these objective criteria apply, regardless of the desire or “will” of the person in question. As a matter of the operation of the law, they are what are called, in legal terms, conditions precedent to the exercise of the decision by the applicant for euthanasia. They are assessments of “value” (or “value judgements”) which logically precede the question of the individual’s desire.

...

The law then, explicitly and objectively, concludes that one human life has an intrinsic value that another does not.

I would recommend that article to those who are really interested. Peter Quinlan goes through some subjective and objective criteria. He refers to the right that already exists in law for people to refuse medical treatment and also the rights that people have to drugs such as morphine and matters that people have already spoken about during this debate.

My learned colleague the member for Armadale raised his concerns about the safeguards. He also raised the question of whether any amount of palliative care would be enough to quell the concerns of those who oppose the principle of euthanasia. That certainly gave me pause for thought. Ultimately, for me, this is a matter of principle. It is about what is right and what is wrong. It is about the sanctity of human life. It is about protecting the most vulnerable, the elderly, those with disabilities and the sick. It is about not putting a price on human life.

Can we give some people the choice without effectively infringing on the choices of others? I do not think so because in giving some people this choice, there will be consequences for others in our community, potentially those people who are vulnerable, who are disadvantaged, who are not so well off or who do not have the choices in life that we have in this place. Many people may well make the choice voluntarily, as those who support the legislation would like, but can we be assured that others will not feel subtly or less than subtly effectively persuaded to make a choice that others believe is best for them? The choice argument does not stand. It assumes that all choices are freely exercised without external, social or economic constraints. This is a nonsense, especially when speaking of the severing of human relationships. In this concept, we are all inextricably part of one another and the neoliberal atomism of our community into individuals exercising free and rational choices is shown to be a devastating and alienating model for living our lives.

I would like to close by quoting one of my favourite metaphysical poets, John Donne, from “Meditation XVII”, which reads —

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No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were: any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bells toll; it tolls for thee.

**MR D.R. MICHAEL (Balcatta)** [8.49 pm]: Madam Acting Speaker, thank you for the opportunity to contribute to this debate on the Voluntary Assisted Dying Bill 2019, especially given that I am the last speaker before the Minister for Health replies. After hearing the many life experiences recounted by members in this debate so far, I consider myself lucky that in my life I have not had the experience of a close friend or family member dying after prolonged disease or suffering. Thankfully, my fiancée, parents, uncles and aunts are well and truly alive. The thought of a loved one dying brings me to think of my grandparents, who have all passed away. Although when they got older they had various illnesses and diseases, from what I observed none of them suffered greatly in their last months, weeks, days and hours. All had a relatively quick death without the prolonged suffering, loss of dignity and pain that this bill aims to address and alleviate. Two of my grandparents died very quickly at the hand of morphine. In an almost unspoken understanding or covenant with family members, discussion of this was somewhat swept under the carpet at the time. However, I know that the morphine alleviated their suffering. In assessing this bill, I have to rely on the findings of and the stories and experiences related to the Joint Select Committee on End of Life Choices and the Ministerial Expert Panel on Voluntary Assisted Dying, as well as those from my constituents and from this debate. I have received many letters, calls and emails from constituents about the Voluntary Assisted Dying Bill and I appreciate the time they took to put their views to me. I received a large amount of correspondence urging me to vote in favour of the bill and, of course, I also received correspondence from people who do not support the legislation. The constituents who wrote to me and are opposed to the bill had three major concerns—the coercion of vulnerable people, the legislation being used for non-terminal patients and the lack of access to palliative care. I will quote some of the correspondence that I received. According to my notes, one person wrote —

Taking one's own life, whether assisted or not, is "suicide" by definition ... When the Government spends so much on mental health care, but then takes steps to introduce a system that not only enables suicide, but actively promotes it as an appropriate response to physical or existential suffering, it says to the community: That suicide is okay; —

**The ACTING SPEAKER (Ms M.M. Quirk)**: Member for Morley, you just walked in front of the speaker. Please continue.

**Mr D.R. MICHAEL**: It continues —

that people's daily battles to live aren't important; and, that people's work to prevent suicide is worth nothing. We don't prevent suicide by assisting suicide."

According to my notes, another constituent wrote —

The solution for improving end of life care is highly accessible palliative care during a time of great emotional distress, not killing patients. Wrongful deaths are guaranteed by this bill, which has even less safeguards than Victoria. No permit will be required to ensure a legal and robust process. There is no requirement for expert assessment of patient capacity.

I thank and respect these constituents for sharing their views with me, but after seeing the legislation, I believe that these concerns have been alleviated. The Voluntary Assisted Dying Bill 2019 was drafted following extensive community consultation undertaken by the Ministerial Expert Panel on Voluntary Assisted Dying. It includes strict eligibility conditions as well as 102 safeguards, with stringent measures to assess a person's capacity and to ensure the protection of vulnerable people. This bill is more conservative and narrower in its possible application and has more safeguards than does the Victorian legislation and the legislation in most other jurisdictions with this type of legislation enacted. I do not believe that this bill is a slippery slope. The debate in this house, with a conscience vote, shows that we are more than capable of dealing with legislation on its merits and the Voluntary Assisted Dying Bill is what we are dealing with.

This bill will set up a very rigorous process in which two independent medical practitioners will be required to assess the eligibility of people seeking to access voluntary assisted dying. They must be over 18 years and an Australian citizen or permanent resident who has resided in Western Australia for at least a year. They will also be assessed as to whether their disease, illness or medical condition is advanced, progressive and will, on the balance of probabilities, cause their death within six months, or 12 months if it is a neurodegenerative condition. The patient will also be assessed as to whether the condition is causing suffering that cannot be relieved in a manner

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that the patient considers tolerable. Throughout this process, independent medical practitioners will assess whether a patient has decision-making capacity while also investigating any signs of coercion or pressure on vulnerable patients to end their lives. There is a requirement in the bill for practitioners who are making these assessments to also ensure that they have discussions about palliative care and other treatment options. There are 102 safeguards in the bill that strike the right balance between providing the stringent safeguards necessary to protect vulnerable people while ensuring that eligible people who genuinely wish to access voluntary assisted dying to relieve their suffering are not prevented from doing so. I am satisfied that this bill contains sufficient protections. There are those strict eligibility conditions and an assessment that the person who is seeking access to voluntary assisted dying has decision-making capacity free from coercion. They must be dying and in the final weeks and months of life and they must make the request themselves on three separate occasions—twice verbally, and once in writing and witnessed by two independent people who will not benefit financially in any way from the death of the applicant.

**The ACTING SPEAKER:** Members, there are three or four conversations going on, which makes it hard for the member for Balcatta.

**Mr D.R. MICHAEL:** Only qualified and suitably experienced and trained medical practitioners may assess a person's eligibility, and they must submit all relevant information to the Voluntary Assisted Dying Review Board, which will supervise the entire process. There is a strict management regime for the voluntary assisted dying substance, including the requirement of the appointment of a responsible contact person and the introduction of several significant new criminal offences for those who act outside the legislation.

I commend the McGowan government for its commitment to bring the palliative care choice to many more Western Australians, with a \$41 million commitment in the most recent state budget and over \$200 million allocated over the forward estimates. I can imagine, as has been mentioned by many members, that there will continue to be a demand for these services into the future. I encourage the state government and all future state governments to continue to expand the availability of this service should someone choose palliative care in the last stages of their life, no matter their postcode or bank balance. I hope to see palliative care beds at Osbourne Park Hospital one day soon and I will continue to advocate for this given that the Morrison government did not match federal Labor's commitment to fund this proposal in the most recent federal election.

The bill's safeguards, the increased access to palliative care for Western Australians and the regulations around who may apply for voluntary assisted dying give me confidence that this is a conservative bill that will protect the vulnerable and is worthy of support.

I have received many letters and emails from people in Balcatta whose loved ones have been terminally ill and they have had to witness that person suffer an agonising death due to illness. In every case these constituents have encouraged me to vote in favour of voluntary assisted dying legislation. I will put on record some of the moving stories from people in Balcatta. According to my notes, one story reads —

I watched my mother die horribly of emphysema. Every breath became a struggle for her, every moment was agony. She had been a long-term supporter of the right to assisted dying, but due to the current laws she was unable to end her torment in the way she wished. I would not wish her death on anybody—it was long and hard, and intensely traumatising for her and for all who knew and loved her. When life becomes intolerable due to a medical condition, people deserve to have their wish to end the agony.

Some members may have read the story on the front page of *The West Australian* recently in which Joondanna resident Kate Law shared her story. She wrote —

I watched my 73-year-old mother die in distress after a long battle with breast cancer that had spread to her bones, causing many of them to break and never properly heal.

I have seen firsthand that palliative care cannot alleviate all forms of pain, leaving the patient and their family in a horrifyingly helpless situation representative of a Third World predicament.

The memory of my mum writhing in pain and begging me not to let her die like this continues to haunt me.

Passing voluntary assisted dying legislation in WA and giving people a choice to end their lives peacefully is the essence of humanity.

Another constituent shared her story in which, despite the great care given to her ill mother, the last two weeks of her life were unbearable. According to my notes, she wrote —

It was fortunate that mother was extremely well cared for and for that I am grateful indeed. Tears dried up, requiring regular eye drops, saliva failed, so her mouth had to be swabbed regularly to prevent ulcers, her body turned regularly to prevent bed sores and regularly checked for bowel and urine action. The last

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two weeks of her life resulted in her not accepting food but fluids were possible. Her weight dropped markedly to the point her skin was draped over her bones. Some weeks prior to the end, I pleaded with the doctor to put an end to her life. The gutless blighter was too concerned due to the possible repercussions. That legally his hands were tied. My poor old mother finally died of starvation and certainly no dignity.

I have had other constituents speak of lonely suicides or the suicide attempts of loved ones who have had enough of their suffering or, in the case of healthcare workers and emergency service personnel, who have had to experience attending such events and deal with the emotional impacts.

I will be voting in support of this bill because I am satisfied that it delivers the safeguards and protections that are appropriate to protect vulnerable people in our community.

I will be voting in support of this bill because relying on a person to starve themselves to death or to attempt suicide in another fashion is neither dignified nor humane. These personal stories have moved me. I cannot reconcile the ways in which some people are dying when we have it within our power to do something about improving their situation. Let us be clear: voluntary assisted dying is not a choice everyone will take, but let us give those who want it, or who want the peace of mind of knowing it is there if they need it and are eligible for it, a safe, compassionate and transparent framework to access.

In conclusion, I have made my mind up on this legislation based on three things: commitments I made in the lead-up to the 2017 election; the views and experiences of my constituents; and my personal values and views. In the lead-up to 2017 election, as I doorknocked just over 7 000 doors in Balcatta and received hundreds of emails, I was regularly asked about my views on voluntary assisted dying. Most of the time I did not know the views of the person asking the question so, as a candidate, I always answered with some trepidation. My email reply to the large number of emails I received on this issue was that should such a bill come to Parliament, whilst I had no moral objections on the issue, I would base my vote on the views of my electorate and ensure that any such bill would be well drafted and have adequate protections for the most vulnerable in our community.

This is the commitment I am following through on today. Given the protections I have already alluded to and the large number of other safeguards contained in the bill, some of which have been spoken about already in this debate, I am confident that the bill will protect the most vulnerable in our community. With regard to the views of my community, I have outlined the main concerns that have been raised with me and how the bill, in my eyes, addresses those concerns. I have also tried to give the house an insight into the lived experience of some of the supporters of this legislation who live in the Balcatta electorate. Some people with terminal illnesses are killing themselves; some are refusing treatment or starving themselves; and some are dying horrible deaths. People who are suffering terribly at the end of their lives should have the right to choose.

I support this legislation because I agree with the majority of views expressed to me by the people in my electorate. My decision was not based solely on community support of voluntary assisted dying; this issue is far too important to be just a popularity contest. However, it is important to mention that every published poll on this issue has shown that an overwhelming number of Western Australians support voluntary assisted dying. Of the constituents in the electorate of Balcatta that I have had contact with, the vast majority I have spoken to or who have written, called or emailed me, support this legislation. In choosing to support this bill, I know that I will however disappoint those in my community who have deeply held views in opposition to the bill. Please be assured that I respect your views and acknowledge what this debate means to you.

Finally, my personal views. Those who know me, know that I strongly value fairness, kindness and compassion. My moral code is that all sentient beings should be free from fear, pain and suffering. I am absolutely convinced that some humans, as sentient beings, are being subjected to unnecessary fear, pain and suffering at the end of their life, and that there is no level of pain relief, sedation or other palliative care that can remedy that. That is why I support this legislation, and that is why I commend it to the house.

**MR R.H. COOK (Kwinana — Minister for Health)** [9.03 pm] — in reply: I take great pleasure in concluding the second reading debate on the Voluntary Assisted Dying Bill 2019. I begin by thanking all members for their contributions. The leaders on both sides of the chamber called for civil, respectful, compassionate contributions from all members, and I think we have done ourselves proud; we have done a particularly good job. I particularly acknowledge those members who have shared difficult personal stories: the member for Scarborough, the member for Central Wheatbelt, the member for Murray–Wellington, the member for Kalamunda, the member for Fremantle and others who shared firsthand accounts of the death of loved ones, including both good and bad deaths. This has not been a particularly easy debate for many members, and I want to acknowledge the efforts made by everyone in bringing those stories to bear in this debate.

**Extract from Hansard**

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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I also want to acknowledge Belinda Teh and Noreen Fynn. Their suffering has become emblematic of the many families across the community who have borne witness to the harrowing last days of their loved ones. Both Noreen and Belinda have demonstrated great courage during the community debate, and I commend them for the way in which they have conducted themselves.

The evidence is clear: complete relief of suffering is not always possible without optimal palliative care. To argue that palliative care achieves complete relief is to deny the reality of those who have shared with us their personal experiences. Palliative care is the solution for nearly everyone; I think that has been accepted and acknowledged, but it is not the solution for all people when it comes to end-of-life experiences. It is also clear from the evidence that compassionate assistance is already rendered to those for whom death is imminent, but such assistance is reliant on the decision-making of a medical practitioner, with no safeguards and no consent.

When suffering cannot be relieved, this bill will provide a safe and compassionate way to access voluntary assisted dying, and it will do so in a way that provides a choice—a choice based on enduring consent, and a choice that, if faced with such suffering at the end of their life, the vast majority of Western Australians have indicated they want such patients to be able to consider.

Friedrich Nietzsche said —

One should die proudly when it is no longer possible to live proudly.

I paraphrase the member for Vasse—and I apologise if I massacre the line—who said we need to have a right to die with dignity because living with dignity is no longer an option.

This bill would not have been possible without the diligence and thoughtful deliberations of the cross-party Joint Select Committee on End of Life Choices, chaired by the member for Morley, with significant inputs from others, including the member for South Perth. I would also like to acknowledge the remarkable work of the Ministerial Expert Panel on Voluntary Assisted Dying led by chair, Malcolm McCusker. I might observe that, contrary to some commentary, it is not correct to say that the panel did not invite comment from those opposed to this bill. The panel welcomed and indeed heard contributions from those who are opposed to voluntary assisted dying in relation to the specific elements that informed workable legislation.

I might also say that the member for Cottesloe's comments—that the common and unequivocal view of palliative care experts is that there is never a clinical reason for a person to experience pain when dying and that pain at the end of life comes about through a lack of palliative care specialists—are not borne out by the evidence. Australian data from the Palliative Care Outcomes Collaboration shows that a small percentage of people, even those being cared for in specialist palliative care services, experience pain at the end of life. It is also clear that people are motivated to request voluntary assisted dying for a range of complex reasons, which are not specific to pain management only. Professor Kathy Eagar told the ABC that when it came to choosing euthanasia, pain did not make it into even the top five reasons; the most common reason is the person not wanting to lose their independence and autonomy.

The premise of this bill is not, as one member stated, that an ideal version of death is a controlled death. The purpose of the bill is to provide choice, for an expected small number of people already nearing the end of their life, over the timing and manner of death. Voluntary assisted dying does not preclude or prevent palliative care; these are not either/or choices. We are considering the compassion we show to those people for whom palliative care does not relieve suffering. The provision of voluntary assisted dying in Western Australia will be part of a continuum of end-of-life care choices available to the Western Australian public; it is not instead of palliative care. People need to bear in mind that there is always more we can do in palliative care and there is always more we can do in health, and we must endeavour to do so.

A number of members commented that we need to do more for palliative care, especially in the regions. The government is doing more and providing record levels of funding. Across the forward estimates, \$206.2 million has been invested in palliative care. Of this, a total of \$58.9 million will be provided to regional services. The total funding for community palliative care in 2019–20 is \$47.2 million, up from \$38.7 million in 2016–17. This level of funding stands in stark contrast with previous investments in palliative care services in Western Australia and represents a significant uplift in our efforts. This bill is not about voluntary assisted dying instead of palliative care. As the member for Morley noted, Palliative Care Australia's own survey of international jurisdictions demonstrates that in those jurisdictions where assisted dying is lawful, palliative care services have been significantly boosted.

Some members referred to WA having a low number of inpatient palliative care beds. I simply want to put on the record that this fails to take into consideration the unique service arrangements we have in Western Australia. Western Australia is the only jurisdiction in the nation to fund the Silver Chain hospice care service in the way

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that we do to provide specialist palliative care services in the community. It is a model that other states are looking to replicate. The Silver Chain hospice care service in Western Australia provides community and consultation services along with specialist palliative care in-home services across the Perth metropolitan area and is extending into the regions. The Silver Chain hospice care service has demonstrated reductions in hospital-based care, reductions in length of stay, and increased likelihood of dying out of hospital. As all members would have seen in their research, the overwhelming preference for people facing their end-of-life situation is that they die at home surrounded by loved ones.

In the 2019–20 budget, total funding allocated to Silver Chain for palliative care was \$22.5 million. The state government is currently considering funding for Silver Chain in accordance with the joint select committee's recommendations in its "My Life, My Choice" report. Members, particularly the member for Kimberley and the member for Kalgoorlie, raised the point that some Aboriginal communities experience a lack of access to culturally appropriate local palliative care and that it is important for Aboriginal people to be given the opportunity to die on country, and for the configuration of those services to take into account collective decision-making. I want to familiarise members with the work done by the ministerial expert panel in its quite extensive consultations with the Aboriginal community. Advice was sought from the Aboriginal health policy directorate in the Department of Health and the Aboriginal Health Council of Western Australia regarding the approach to consulting Aboriginal stakeholders. The information was provided to participants at the AHCWA state conference in March this year. An information session was held with the AHCWA CEO network in April this year. As members would know, the network of Aboriginal-controlled community health organisations is extensive. AHCWA also provided a written submission to the Ministerial Expert Panel on Voluntary Assisted Dying. I spoke this week with the chair of AHCWA who, once again, committed the council's support for this legislation.

Improving access to culturally appropriate palliative care provided in the person's place of choice forms part of priority 1 of the "WA End-of-Life and Palliative Care Strategy 2018–2028". The government accepts that it is important to consider the needs of people from diverse backgrounds who may be from cultures that have a collective approach to decision-making. I thank the member for Kimberley for reminding us of the need to improve communications with people for whom English is not their first language. The expert panel paid particular attention to the needs of culturally and linguistically diverse people, Aboriginal people and members of vulnerable population groups, as well as those living in rural and remote areas. I anticipate that the implementation will establish a care navigator service to ensure that the needs of Aboriginal people are identified and provided for in the operation of the bill. The Department of Health is already considering the development of a care navigator model similar to that used in Victoria, with a focus on enabling access to voluntary assisted dying for people living in rural and remote areas.

The issue of coercion was raised by a number of members in this place. Some members contended that the bill does not go far enough to protect the vulnerable; that one of the practitioners should have a prior relationship with the person; and that we cannot be sure that a patient takes medication at the time of their own choice and not after coercion by a family member. It is important for members to consider these facts: repeated, independent and exhaustive reviews have shown no evidence of abuse of the vulnerable in overseas jurisdictions. Evidence from both Oregon and the Netherlands demonstrates that members of vulnerable groups are no more likely to receive assistance in dying, and that the demographic profile was typically people with comparative social, economic, educational and professional advantage. This regime does not of itself prey upon the disadvantaged and the vulnerable.

The member for Warren–Blackwood referred the house to the 2016 Australian Human Rights Commission report that stated —

Well drafted 'proactive' legislation permitting and regulating active voluntary euthanasia can deliver certainty, transparency and above all, protection to all who may be involved in these practices.

The member for Morley reminded us that this bill will protect vulnerable people in ways that do not exist now and that opponents are actually arguing for the substandard status quo to remain.

An assessment to determine whether the decision was made voluntarily and to detect coercion will form an explicit component of the mandatory training that a coordinating or consulting practitioner would be required to undertake. Medical practitioners will have experience in determining that a person has not been unduly influenced by health professionals, friends or family, via longstanding application of consent to treatment processes. A requirement for a person to have a prior relationship with one of the practitioners could unfairly exclude someone whose usual practitioner refuses, conscientiously objects, is ineligible or has not undertaken the training. This would be a significant access and equity issue for people in regional and remote parts of Western Australia.

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The bill includes safeguards to ensure a person is acting freely. Clause 15(1)(d) provides that the eligibility criteria for voluntary assisted dying include the requirement that a person has acted voluntarily and without coercion. Clauses 23 and 34 provide that a person is required to be assessed against eligibility criteria by two independent medical practitioners. Clauses 27(2)(a) and 38(2) provide that if the medical practitioner is not satisfied that the person is acting voluntarily and without coercion, they must assess the person as ineligible. Clauses 25(3) and 36(3) provide that if the medical practitioner is unable to make a determination on this matter, they must make a referral to a person with the appropriate skills and training to make that determination. Clause 54 requires that the medical practitioner must be satisfied the patient is not being coerced prior to the issuing of a prescription. Clause 58(5) also requires this prior to administration in the case of practitioner administration. The bill provides that an application may be made to the State Administrative Tribunal for a review of a decision that the person is acting voluntarily and without coercion. The process is suspended whilst the review application is determined. The SAT has indicated that it would attempt to resolve the matter in an expeditious manner.

Express offence provisions reflect that coercion will not be tolerated in relation to voluntary assisted dying. Severe penalties, ranging from a summary conviction of three years' imprisonment to life imprisonment, have been drafted. The bill makes it clear that the *parens patriae* jurisdiction of the Supreme Court is not excluded. The Supreme Court may, in the exercise of its *parens patriae* jurisdiction, make orders for the protection of vulnerable people, such as children, the mentally ill and the elderly.

Some in this chamber have made the suggestion that voluntary assisted dying will be seen as a solution to dealing with the complex issues of ageing and dying and that there could be a temptation to avoid costs and complexity by encouraging people down this path. The member for Girrawheen raised concerns that these laws will be seen as a way out for those who have outlived their usefulness. This bill does not address the concerns related to aged care or quality of life in older Western Australians. It sets out to provide choice for a small number of people who have a life-ending illness and are nearing the end of their life in the timing and manner of their death. A review of the aged care sector in Australia is currently the focus of the Royal Commission into Aged Care Quality and Safety. The Western Australian government is committed to preventing and addressing elder abuse. One of the four priority areas outlined in the "Draft WA Strategy to Respond to the Abuse of Older People (Elder Abuse)" is to support older people to remain socially connected and to provide avenues to seek help. A further priority area is to safeguard and support older people with accessible support and justice responses. The government also funds an elder abuse helpline, which provides confidential advice and information to protect themselves and others from elder abuse. The Alliance for the Prevention of Elder Abuse: Western Australia, a collaboration between the departments of health, local government and communities, has a 2013 elder abuse protocol that includes guidelines for action and sets out emergency and non-urgent referral pathways. The mandatory training provided under the Voluntary Assisted Dying Bill will include the identification of risk factors for abuse.

In relation to safeguards, some members have incorrectly asserted that there are fewer protections than in the Victorian law. I can assure members that this is just not true. As an example, the permit system in Victoria, which a number of members have referred to, does not offer any further protections. It is a bureaucratic layer that already exists in the health system for medicines and poisons. The WA bill reflects practices consistent with how medicines and poisons are issued in this state. We already have our own permit and authorisation system. There is no need to replicate it in this bill. Furthermore, the bill applies tighter restrictions to the voluntary assisted dying substance. Whereas the Victorian legislation uses the permit system to authorise particular acts, the WA bill expressly authorises them in legislation. The Voluntary Assisted Dying Bill 2019 is amongst the most conservative and restrictive in the world. It is important to remember that safeguarding is about doing everything possible to keep people safe, without diminishing their human rights.

I acknowledge the comments of the member for Moore about patients who are suffering from dementia or other cognitive degenerative disorders. I think it is fair to say that we could not, in all conscience, satisfy ourselves that that person could meet the decision-making capacity criteria.

The member for Morley rightly reminded us all that terminal sedation may be undertaken without consent and that the 10 per cent of suicides related to chronic or terminal conditions are the current wrongful deaths that members are keen to avoid. Neither of these outcomes should be acceptable to members.

A number of members, and in particular the member for Armadale, raised the issue that a medical practitioner should not be allowed to raise voluntary assisted dying as part of the patient care options. I think it is fair to say that the panel carefully weighed the outcomes of the consultation on this issue. In fact, I will quote from the panel's report —

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The Panel carefully weighed the outcomes of the consultation and knowledge of other jurisdictions, with the unique cultural circumstances of Western Australia in its deliberations on this matter.

The Panel believes that health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying.

The Panel acknowledges the position of the Joint Select Committee and agrees that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with patients, including that there be no prohibition on health practitioners appropriately raising the subject of voluntary assisted dying.

In short, we do not believe that it is appropriate that we should second-guess the conversation between a patient and their doctor.

Concern was also expressed by the member for Cottesloe that there may be an expansion of the bill in future to give a wider range of people access to voluntary assisted dying—for example, those with dementia. As I said, the member for Moore also raised those concerns. However, as the Attorney General has already explicitly stated, this government does not, and will not in the future, support the proposal to include voluntary assisted dying in an advance request for those with dementia. Belgium and the Netherlands are often cited as examples where scope creep has occurred. Access to voluntary assisted dying in these countries has never been limited to people with a life-limiting illness; a person needs only to be suffering. In jurisdictions with more restrictive eligibility criteria and more rigorous processes, such as those in the United States, there is no evidence that the scope has been informally expanded. In the 22 years that the Oregon Death with Dignity Act has been in place, there has been a single amendment to allow the 15-day waiting period to be waived if death is likely to occur before expiry of the waiting period. The ability to waive the waiting period in some circumstances is consistent with legislation in Victoria and Canada and the proposed WA bill. However, no further amendments have been made to the Oregon legislation since it was legislated for 22 years ago.

The bill provides for the ethical, moral and professional objections to voluntary assisted dying held by some medical practitioners, but balances this with the need to facilitate timely and appropriate access to people who request voluntary assisted dying. Practitioners are not obliged to refer persons seeking voluntary assisted dying directly on, but they are required to inform the patient of their refusal and give the person information about voluntary assisted dying. Faith-based hospitals are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. A person seeking to access voluntary assisted dying may be required to transfer to a particular hospital or care facility. Practitioners at those facilities remain bound by ethical and professional obligations to ensure proper care and timely transfer. However, evidence from overseas shows that most people wish to die at home.

It is incorrect to say that clause 10 of the bill has the effect that a medical practitioner cannot tell a patient that there is a better way to be treated than to access assisted dying. This clause does not prevent a medical practitioner from informing a patient about treatment options. A medical practitioner is able to raise and discuss assisted dying with a patient. Indeed, under clauses 26 and 37, medical practitioners are required to inform the patient of all the treatment options, including palliative care. Clause 10 provides that when a registered health practitioner contravenes a provision of the legislation, that contravention is capable of constituting professional misconduct or unprofessional conduct. Professional misconduct or unprofessional conduct will be ascertained pursuant to the Health Practitioner Regulation National Law (WA) Act. The act creates a suite of offences so that a contravention of a particular provision attracts criminal liability.

With regard to mental health, a person is not eligible to access voluntary assisted dying only because the person has a mental health issue. However, having a mental health issue does not preclude a person from accessing voluntary assisted dying when they otherwise meet all the other eligibility criteria to do so. Decision-making capacity is obviously an important element and is required at every step of the voluntary assisted dying process. Determining whether a person is able to make a treatment decision is part of current professional health practice. Doctors routinely assess decision-making capacity now—decisions made by their patients to consent to or refuse dialysis, to consent to or refuse chemotherapy, to consent to or refuse surgical interventions or to forgo treatment that may result in the patient's death. Under the bill the coordinating consulting practitioners must refer to a relevant health practitioner, such as a psychiatrist, geriatrician or psychologist, if they are unable to determine capacity. This is the approach that was endorsed by the Royal Australian and New Zealand College of Psychiatrists in its submission to the Joint Select Committee on End of Life Choices, and I quote —

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Where there is some question regarding capacity or the potential of treatable mental illness then the RANZCP WA Branch would support a framework in which it is mandatory to consider psychiatric assessment.

The bill does not overturn the fundamental legal principle that an adult is presumed to have decision-making capacity, but where there is a question, where there is doubt, the practitioner must refer for a specialist assessment.

The coordinating practitioner must also complete a final review that certifies by way of signed statement that the practitioner is satisfied that the person has decision-making capacity, is acting voluntarily and without coercion, and that the person's request is enduring. Practitioners are required to undertake mandatory training that will emphasise the importance of referral for specialist opinion when there is any concern that a mental health issue may be adversely impacting the decision a person is making to access voluntary assisted dying. GPs already conduct detailed mental health assessments of their patients for the purposes of mental health care plans. These are not undertaken during short consultations, but require long appointments to enable GPs to properly assess the mental health needs of their patients.

The training package in WA will be developed in consultation with the Department of Health; key medical nursing and allied health stakeholders and experts; palliative care and end-of-life stakeholders; and cultural stakeholders and advisers and consumer community representatives. Training will be informed by the mandatory training program in place in Victoria, noting that there will be different and additional requirements in Western Australia. The Royal Australian College of General Practitioners will be involved in the development and accreditation of training to ensure that it is effective and meets required standards. In addition, in its submission to the Joint Select Committee on End of Life Choices, the WA branch of the Royal Australian and New Zealand College of Psychiatrists noted, and I quote, "psychiatrists are well placed to support upskilling colleagues" in relation to capacity assessment. The training will contain competency assessments and a successful pass is required for the training requirements to be met.

Mentoring programs and support networks will be vital for providing support not only to medical practitioners but all health professionals involved in the voluntary assisted dying process, including those who decide not to participate. Frameworks for establishing and encouraging growth of these support systems across the state will be developed during the implementation phase in consultation with key medical, nursing and allied health stakeholders. As in Victoria, it is likely that mandatory training will include advice on self-care for medical practitioners, as well as information on where to access support services.

All of us in this chamber are aware of the challenges in delivering world-class health care across the single largest jurisdiction in the world. The bill has been drafted in full awareness of the challenges faced by regional Western Australians and seeks to enhance accessibility through the inclusion of nurse practitioners and provision of the appropriate use of technology. Although we acknowledge the challenge of service access equity across rural and remote WA, it is not the purpose of the Voluntary Assisted Dying Bill to address underlying issues related to access to health services. During the implementation, the government will work closely with regional stakeholders such as the WA Country Health Services, the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the Australian College of Nurse Practitioners and other relevant stakeholders to facilitate access for rural and remote Western Australians.

Members have sought clarification regarding the use of telecommunications in the request and assessment process given the commonwealth legislation that is in place. The Department of Health is aware of the provisions of the commonwealth Criminal Code Act 1995 about the use of carriage services for suicide-related material and the instruction given to medical practitioners in Victoria. The commonwealth provisions were introduced to deal with the phenomena of cyber-suicide and pro-suicide websites. Section 474.29A prohibits a person from using a carriage service for suicide-related material, including material capable of constituting a communication which directly or indirectly counsels or incites committing or attempting to commit suicide. Section 474.29B prohibits a person from possessing, controlling, producing, supplying or obtaining suicide-related materials for use through a carriage service. State legislation cannot override commonwealth legislation. The Department of Health has taken the view that voluntary assisted dying is not suicide. Clause 11 of the bill states as such. This view is supported by the Department of Justice. Furthermore, the Department of Health has taken the view that the commonwealth provisions were not intended to include circumstances related to voluntary assisted dying. This view is supported by the Department of Justice.

There has been some preliminary communication between the Department of Health and the commonwealth Attorney General's department. The Western Australian Attorney General has written to the commonwealth Attorney General to ascertain the commonwealth government's position with a view to seeking an undertaking

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that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to make it clear that the provisions do not apply to voluntary assisted dying. The bill makes it clear that it does not authorise the use of a method of communication if, or to the extent that, the use is contrary to or inconsistent with a law of the commonwealth. If the bill becomes law, there will be an implementation period of at least 18 months before the Voluntary Assisted Dying Act becomes operational. I anticipate that, if necessary, the Department of Health will ensure patients who wish to explore voluntary assisted dying will be supported in doing so, including face-to-face consultations. The commonwealth legislation will not be an impediment to the operation of this bill.

Some members of this house who are opposed to the bill contend that prognosis cannot be predicted—that there is uncertainty on when a person will die when they are in the final stages of a terminal illness. The member for Cottesloe asserts that scientific literatures supports the overestimation of life expectancy; however, there are a large number of occasions when the prognosis is overly pessimistic, and, further, that safeguards on prognosis will be eroded over time. The truth is that studies show that in most instances doctors are overly optimistic about survival following those who make accurate predictions, and a doctor is shown to be overly pessimistic in only the minority of instances. This is made clear in the 1 December 2016 volume of the *Journal of Palliative Care & Medicine*. The Voluntary Assisted Dying Bill 2019 specifies that a person will be eligible for voluntary assisted dying only if two medical practitioners have completed the approved voluntary assisted dying training, independently determined along with other criteria that the person is diagnosed with a disease, illness or medical condition that will cause death, and that it will on the balance of probabilities cause death within six months or within a period of 12 months in the case of neurodegenerative conditions. There is no evidence to suggest that the safeguards on eligibility will be eroded over time. In jurisdictions with more restrictive eligibility criteria and more rigorous processes such as those in the US, there is no evidence that the prognosis requirement has been formally or informally expanded.

The member for Dawesville asked how the person will be identified and satisfy the demographic requirements. It is a requirement of the bill that the coordinating consulting practitioners must be satisfied as to the residency status of the patient as part of the assessment against the eligibility criteria. In practical terms, this may include review of the Western Australian driver's licence or other such documentation that establishes the person's identity and residency.

The member for Vasse asked how voluntary assisted dying will be funded and what are the expected costs. As outlined in the bill, a range of medical practitioners will be eligible to provide services—clause 16—as well as limited scope for nurse practitioners to provides services, outlined in clause 53.

Funding for individual services will need to be compliant with current Medicare billing guidelines. Although some standard consultation items may be applicable, it is recognised that the time invested by practitioners may exceed that which is usually provided for and will need to be further addressed during implementation planning. I anticipate that patients will be subject to the usual Medicare billing arrangements as would normally apply when seeing a doctor.

During the implementation phase, a clinical expert panel will be convened to determine the appropriate schedule 4 and 8 substances and protocols for voluntary assisted dying, as raised by the member for Darling Range. The pharmaceutical benefits scheme is a commonwealth scheme that lists medications available to all Australian residents who hold a Medicare card at a government-subsidised price. It is expected that the voluntary assisted dying medications would not be on the PBS, and I anticipate that the cost of voluntary assisted dying medications will be covered by WA taxpayers, as is occurring in Victoria. Until such time as the specified medications are determined by the clinical expert panel, the cost to the state cannot be confirmed.

The member for Dawesville also raised a question about the level of coordinating consulting commerciality that may exist with practitioners. Based on overseas evidence, the rate of people accessing voluntary assisted dying ranges from 0.4 per cent in Oregon to four per cent in the Netherlands. Given that this bill is reflective of the Oregon framework—that is, a person must be dying and their death will probably occur within six months—it is more likely that our rates of voluntary assisted dying deaths will be closer to Oregon's rates. Given those very low rates, voluntary assisted dying will not be a commercial prospect for any health practitioner.

Members have raised the issue of handling and safety of voluntary assisted dying substances. For medication, the bill includes requirements that are consistent with the Medicines and Poisons Act 2014 and also specifies additional requirements. The Medicines and Poisons Act 2014 and regulations specify the requirements for the safe transport, storage and disposal of medications. The Voluntary Assisted Dying Bill 2019 includes additional requirements to ensure the safe and secure management of voluntary assisted dying medications in a way that

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can be appropriately tailored to a patient's appropriate situation. Before prescribing the voluntary assisted dying substance, the prescriber must provide the patient with information on appropriate storage, preparation, how to self-administer and, if necessary, disposal of any unused or remaining substance. Clause 71 provides that when supplying a prescribed substance, the authorised supplier must also provide the same storage, preparation, administration and disposal information to the recipient. Clause 73 provides that medication supply be notified to the Voluntary Assisted Dying Board as well as registered according to the existing requirements of the Medicines and Poisons Act 2014 and regulations. Provisions of this act have been included in the bill to provide a high level of safety and ensure compliance. A police officer or an investigator appointed by the CEO can investigate noncompliance.

In WA, schedule 4 and 8 poisons, which will make up the voluntary assisted dying substances, are already dispensed to people without the legislative requirement of a locked box. All medications should be stored securely. The requirement for medications to be dispensed in locked boxes may introduce problems for patients with poor manual dexterity. Patients who are often confined to bed may be able to self-administer medications, but may not be able to locate and open a box. Furthermore, governance and locations of the key to the locked box potentially misplacing confidence in the integrity of the security offered by the locked cash box, as used in Victoria, may be an issue.

I will provide further detail on the medication processes at the consideration in detail stage. A number of members have raised the issue of pharmacy dispense and control. We anticipate that we will operate a hub-and-spoke model for the prescription of medications and dispense and disposal of any unused medications for regional and remote patients.

The member for Cottesloe indicated his concern about the nine-day time frame for a reflection period. The length of the reflection period is intended to strike a balance between minimising the time a person is suffering and ensuring sufficient time has passed to demonstrate that the request is enduring. The addition of a qualification period may unnecessarily extend a person's suffering.

A number of members raised the issue of what is on the death certificate, including the member for Kalgoorlie. The intent of this provision is that the voluntary assisted death will not be listed on the medical certificate or the public death certificate as the cause of death.

I will go to other points at the consideration in detail stage. However, I reiterate to members that this is a watershed moment for the chamber and it is within our power to be courageous, compassionate, decent and fair. The bill offers a beacon of hope for those in our community who experience unnecessary suffering at the end of life. It is an exemplar of safety, freedom and individual autonomy. I reflect on the comments by the member for Midland who commented that no man is an island and that economic, legal and social constraints constrain us all, and we do not have unlimited liberties as individuals. However, through carefully crafted legislation, we can provide this liberty. We can provide someone whose death is imminent and whose pain and suffering is unbearable with a dignified end-of-life choice.

Those who satisfy all the eligibility criteria and who undergo a stringent assessment process will be free to choose. Those who are already dying will be free to end their life in a humane and dignified manner. Freedom is one of the deepest and noblest aspirations of the human spirit. Members, we must have the courage and the confidence to uphold these freedoms for the most vulnerable amongst us. Let us resolve that we as members of this Parliament will not abuse the trust of the community, the trust of more than 88 per cent of Western Australians. Many members have said that we have not done enough and that it is too early, but I put the question to all of you: if not us, then who; and, if not now, when?

I commend the bill to the house.

*Division*

Question put and a division taken with the following result —

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]  
p6276b-6341a

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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Ayes (44)

Ms L.L. Baker	Mr T.J. Healy	Mr K.J.J. Michel	Ms C.M. Rowe
Dr A.D. Buti	Mr M. Hughes	Mr S.A. Millman	Ms R. Saffioti
Mr J.N. Carey	Mr D.J. Kelly	Mr Y. Mubarakai	Ms J.J. Shaw
Mr V.A. Catania	Mr Z.R.F. Kirkup	Mr M.P. Murray	Mrs J.M.C. Stojkovski
Mrs R.M.J. Clarke	Mr F.M. Logan	Mr K. O'Donnell	Mr C.J. Tallentire
Mr R.H. Cook	Mr W.R. Marmion	Mrs L.M. O'Malley	Mr D.A. Templeman
Ms M.J. Davies	Mr M. McGowan	Mr P. Papalia	Mr P.C. Tinley
Ms J. Farrer	Mr J.E. McGrath	Mr S.J. Price	Mr R.R. Whitby
Mr M.J. Folkard	Ms S.F. McGurk	Mr D.T. Punch	Ms S.E. Winton
Ms J.M. Freeman	Ms L. Mettam	Mr J.R. Quigley	Mr B.S. Wyatt
Ms E.L. Hamilton	Mr D.R. Michael	Mr D.T. Redman	Ms A. Sanderson ( <i>Teller</i> )

Noes (12)

Mrs L.M. Harvey	Mr P.A. Katsambanis	Mr R.S. Love	Ms M.M. Quirk
Dr D.J. Honey	Mr A. Krsticevic	Dr M.D. Nahan	Mrs M.H. Roberts
Mr W.J. Johnston	Mr S.K. L'Estrange	Mr D.C. Nalder	Mrs A.K. Hayden ( <i>Teller</i> )

Question thus passed.

Bill read a second time.

**The ACTING SPEAKER (Ms S.E. Winton):** Members of the public gallery, I would like to remind you that photographs are not permitted.

Leave denied to proceed forthwith to third reading.

*Consideration in Detail*

**Clause 1: Short title —**

**Dr M.D. NAHAN:** I do not want to hold up consideration; this is not a stalling scheme. I would like some background from the minister about the title of the bill. Why was this title chosen? In this debate through history we have evolved various terms such as “euthanasia” and “assisted suicide”. Other bills have been brought to the upper house that had the word “euthanasia” in them. During their second reading contributions, many members raised the issue of the definition of “euthanasia”. A comment from one of the minister’s expert advisers was that the words “voluntary assisted dying” were chosen because of the pejorative nature of the definitions “euthanasia” and “assisted suicide”. Could the minister give us some reasons for “assisted dying” being used in the title? “Assisted dying” could mean many things. Palliative care is sometimes used to assist in the dying process. It is used to help address the pain caused by a disease that will lead to death, as is psychiatric treatment and a whole raft of other activities that, by the way, the government is quite rightly pursuing outside this bill. During my second reading contribution, I applauded the minister for doing that. It is a very good idea. Could the minister give us a rundown on why this title was chosen?

**Mr R.H. COOK:** It is a very important question. We are reflecting the language that has been used in Victoria. In some respects, that has become the modern nomenclature, for want of a better reason. I am advised that euthanasia, as I think the member pointed out in his speech, is a situation in which death is induced to relieve suffering. I have often said to folk that in modern times the word “euthanase” has become the transitive verb; that is, to euthanase is to do something unto someone else. It has had significant connotations. Historically, it has reflected the abuse of involuntary euthanasia, which raises the prospect of medical practitioners or society killing people whose lives are thought to have little value; that is, they are doing the relieving, if you like.

More recently, most people are familiar with the idea of euthanasia from the practice of relieving the suffering of family pets. It is commonly used nowadays in that field as something that we do to a pet to relieve it of its suffering, whereas voluntary assisted dying is explicitly a process during which someone acts of their own free will in their own suffering. When applied to humans, euthanasia is often similarly understood to be a procedure that is provided to a passive patient. By contrast, voluntary assisted dying, as I said, is a process that is requested and led entirely by the person involved.

The member mentioned suicide. Obviously, we make a very strong distinction with suicide. Suicide connotes loss of life of a person who is typically not dying or in circumstances that are often tragic and when the person feels socially or emotionally isolated. Voluntary assisted dying involves a person’s choice about their mode of death, not about whether they will die. Their death is imminent and inevitable. From that perspective, we are making a very

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[ASSEMBLY — Tuesday, 3 September 2019]

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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firm distinction that this is not an exercise in suicide or of euthanasing someone; it is about someone exercising voluntary assisted dying in their own regard.

**Dr M.D. NAHAN:** There are two operative actions under this bill. The primary one is to give a terminally ill person facing imminent death the tools—the poison, if you wish—to end their life. In certain conditions specified in the bill, the bill also allows a physician, a doctor, or perhaps under rare circumstances a nurse, to give the poison to the patient. I am not going to push this but I strongly believe and want to make the point that we are dealing with something important and the title should precisely describe what we are dealing with. That is my point. In the former, it is to assist someone to die voluntarily in their own time and to commit suicide. I am not using that in a pejorative sense. The other one is to have a physician effectively end a person's life under the common definition of the word "euthanasia". Other people have pointed out that there are quite a few definitions of euthanasia. It is very broad. In its Greek translation, I think it would be suitable, but who translates Greek?

Several members interjected.

**Dr M.D. NAHAN:** The member for Hillarys does—Ancient Greek!

The language has changed over the centuries, though not in this case. Is it more precise to use "euthanasia" and "assisted suicide", which are commonly used? During my review of the literature in recent times, when this issue has been debated around the world, those were the terms used. "Assisted dying" is not precise. "Assisted dying" has a whole raft of tools, including palliative care, that are not the focus of this legislation.

**Mr R.H. COOK:** I appreciate the technically descriptive way in which the member has approached the title. As I said, for the reasons I just outlined, we do not believe that this is euthanasia and it is certainly not suicide. In this context, we are trying to describe it in a more respectful and contemporary way. As I said, in the modern context of euthanasia, it is primarily described as something that someone does to something else and most commonly something that people do to a family pet, whereas this is not reflective of that. It certainly cannot be characterised in that way. This is not suicide. Suicide is when someone takes their life for reasons beyond their medical condition—they have simply lost the will to continue living. It is not because they have a life-determining condition. From that perspective, suicide is certainly not appropriate. Voluntary assisted dying is the most thoughtful and respectful title, and we want respect and dignity to be a central value of this bill.

**Mr P.A. KATSAMBANIS:** I was not intending to speak on clause 1 because I accept the proposition that the minister made in his first set of remarks; namely, that over time language can change. The word "euthanasia" proves that. The member for Riverton referred to Ancient Greek. In Ancient Greek, it was "eu thanasia". "Eu" means good, kind or graceful and "thanasia" is the extension of the Greek word "thanatos", which means death. It is meant in its original use as a good or graceful death. It had nothing to do with a death that was induced. It simply means someone who died well, for want of a better word, and they could have died well at the expiry of their own life. It has come 2 400 years later to mean as it was defined on page 20 of the Joint Select Committee on End of Life Choices report, which states that the definition of "euthanasia" is given as meaning the intentional termination of the life of the person by another person to relieve the first person's suffering. That is when I join forces with the member for Riverton in the sense that I think that is a well-established and well-accepted term.

Euthanasia is considered to be the intentional termination of a life of a person by another person to relieve the first person's suffering. People can say that that has become pejorative and that they would like a less pejorative term, and other people would say that the government should use the term that is in common use. I will not get into a debate about that. I was concerned that in the minister's first contribution on this point, he suggested—I am paraphrasing and the minister will correct me if I am wrong—that suicide is someone taking their life when they were not going to die anyway. If that is the case, that is a serious misrepresentation of suicide. Suicide is someone taking their own life—full stop. Period. That is suicide—someone taking their own life. It is not someone taking their own life when they are not dying or might not be dying. It is someone taking their own life—full stop. Period. Let us stop playing with, and twisting, words. We have had a pretty respectful debate. We have our different views. However, I do not think there is any use at all in trying to play around with words. If the minister said that colloquially and did not mean it, I would welcome him correcting the record, because it is not a statement that should stand on the record. If I misheard or misinterpreted him, again, I apologise for that.

Since we have come to this debate, given that it was the Joint Select Committee on End of Life Choices that defined "euthanasia" as meaning the intentional termination of the life of a person by another person to relieve the first person's suffering, and given that there is a clear understanding of that term, why has the government chosen to not use the term? Obviously using the word "voluntary" distinguishes it from involuntary or any other type of euthanasia. It is a deliberate choice. Why has the government chosen to go away from the Joint Select Committee

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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on End of Life Choices' own position on this? I do not like us somehow or other trying to hide what will really happen. As the member for Riverton said in his contribution, under this legislation, people will be able to die in two specific ways. One way will be to request a poison that they will ingest. They may self-administer it or take it home. They may request the assistance of someone they know in the comfort of their own home. As has been proven in jurisdictions in other parts of the world, the other way is for them to request a physician to administer the poison to them. That is not anything other than the intentional termination of a life of a person by another person in order to relieve the first person's suffering. That is euthanasia. Why are we shying away from that term?

**The ACTING SPEAKER (Mr R.S. Love):** Minister, before you speak, Attorney General and Minister for Emergency Services, if you want to have an animated discussion, could you take it outside?

**Mr R.H. COOK:** Thank you, member for Hillarys. I do not necessarily disagree with what the member is saying, and I take note of his learned response about the origins of euthanasia. As I said to the member for Riverton, the modern usage of the concept of euthanasia is that it involves an involuntary act. I accept the member's advice on the origins of the term. Modern usage of the term euthanasia often connotes an involuntary exercise—that is, the doing of one thing to another person. From that perspective, the debate in this area has moved away from the language of euthanasia. I do not doubt that the member can find reports, and I think I have quoted from reports from just a few years ago, that still use the term “euthanasia”. I am sure we can all find such reports, but, ultimately, I think that the community has moved on in terms of that language because of the way I said it was described. As I said, suicide connotes the loss of life of a person who is typically not dying and in circumstances that are often tragic and the person feels socially or emotionally isolated. The phrase “voluntary assisted dying” emphasises the personal volition and decision-making of the individual involved. Ultimately, the term is consistent with the language used in the Victorian legislation, and the language used by the joint select committee and the ministerial expert panel. From that perspective, we are continuing that approach.

**Dr M.D. NAHAN:** This will be my last comment on this issue. We heard many contributions from members on both sides who said that one of the reasons for this legislation is that people who are in great pain and are facing terminal illnesses commit suicide to end their lives. They do so because of pain and the terminal nature of their diseases. We all heard many members describe that as suicide. I think it is incorrect, in the context of this debate, to define suicide as one person taking their own life not because of terminal illness. The member for Hillarys made it quite clear that suicide is defined as one taking their own life—full stop—for whatever reason. We heard many statements in which members gave statistics and said that one of the reasons for this bill is for people not to have to take their own lives under painful or long and drawn out processes, such as starving themselves or the use of firearms. I do not think it is accurate to say that the definition of the word “suicide” is restricted to those who take their lives but do not have a terminal illness. Again, words are precise; the English language is the most intricate language on earth and we are dealing with an issue that I think requires precision. One of the criticisms or concerns about the bill is its lack of precision and the need to be precise and restrictive on its application. If we use words to sell it rather than words to define it precisely, we could very easily get lost. I think, with all due respect, the minister is not defining “suicide” properly, and I think “euthanasia” fits this bill quite precisely. Nonetheless, I will sit down now and move on.

**Mrs A.K. HAYDEN:** I want to go back to the term “involuntary euthanasia” and ask the minister where he got the information to make him believe that the community has moved on from the term “euthanasia”. Everyone in this place has been out there talking to their communities, their constituents, family and friends. When I talked to them about voluntary assisted dying, they looked at me in puzzlement. When I told them what it is, they said, “Oh, you're talking about euthanasia.” People in general in the community understand what the word “euthanasia” means, and I do not necessarily agree with the minister when he says that the community has moved on from that language and that they now call euthanasia “involuntary euthanasia”. I do not know where that has come from; I do not know which community is telling the minister that, but I can tell him that the community I speak to understands the word “euthanasia”. Voluntary assisted dying is a new term that is being put out there. As the Joint Select Committee on End of Life Choices said, and the member for Hillarys outlined, they even have the meaning of euthanasia as being exactly what this bill intends to do, which is the termination of the life of a person by another person in order to relieve the first person's suffering. I am really confused and concerned, because this is legislation that everyday citizens are going to have to understand and get their heads around. This will affect people who do not have access to palliative care or the internet, especially in regional and remote areas. They are going to be confused. Why are we confusing the language and making it even more difficult for vulnerable people by not letting them know up-front the intention of this legislation?

**Mr R.H. COOK:** I thank the member. As I said in an earlier response, we are informed by the work of the Joint Select Committee on End of Life Choices, which held more than 81 hearings, and we are informed by the Ministerial Expert Panel on Voluntary Assisted Dying, which undertook the most extensive consultation process

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ever conducted by WA Health in relation to all facets of this bill. In that regard, “voluntary assisted dying” is clearly the language that has been used throughout all those processes. Victoria, as I mentioned to the member for Riverton, also uses “voluntary assisted dying”.

I was listening to a sports report the other day and there was a racehorse that broke down in a race. At the end of the report, they said that the horse had been euthanased. That is essentially what has become the common usage of the term, so I simply make that observation. With regard to what gives me the confidence to use the term “voluntary assisted dying”, it was the joint select committee, which undertook an extensive process, and the ministerial expert panel, which undertook an even more extensive process of consultation with the community. In that sense, “voluntary assisted dying” is very much the modern language that is used to describe this process.

**Mr J.E. McGRATH:** I might be able to help the minister because I know a lot of people refer to it as euthanasia, but I recall the member for Nedlands’ speech today. He undertook a survey of his electorate and I think the first question was: do you understand what voluntary assisted dying is? I think 98 per cent of those very wise people from Nedlands said yes. We are going into semantics a bit here. I was a member of the select committee and we discussed this at length. Voluntary assisted dying is the best title for the bill. It is used in other jurisdictions, including Victoria.

This is not suicide. If I wanted to commit suicide, I would just walk outside and throw myself in front of a car. That would be suicide. If I want to participate in voluntary assisted dying, I have to go through a process. No-one who commits suicide goes through a process and says to the wife, “You go off to the shop and when you come back, I will be hanging in the garage.” It does not happen. People just make a decision, for all sorts of reasons, to end their life by suicide. People will have to make a conscious decision to go through that process in a proper way. There is no way that this could be referred to as suicide.

Euthanasia is a little different. As the minister said, an animal is put down when it is in great pain. That is euthanasia. If a person who wants to end their life goes through the process and they are deemed to have full capacity and they are in fact dying—it is not that they are not dying; they have to be dying within six months—it is certainly not euthanasia. It is something that they choose to do. Very strict guidelines have to be adhered to. In some circumstances—there will not be many—they will be able to get some assistance if they cannot actually take the substance themselves. We have to move on from this. People understand what voluntary assisted dying is about. They cannot be under any misapprehension about what we are talking about. When someone is asked whether they support voluntary assisted dying, they never say, “What do you mean?” They say “Yes” or “No”.

**Mr S.K. L'ESTRANGE:** “Euthanasia” is defined on page 20 of the Joint Select Committee on End of Life Choices report. It states, in part —

Euthanasia means the intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.

That is the definition. The minister agrees with that definition because he just said that the joint select committee and the ministerial expert panel went to a lot of trouble to define it. They have defined it—it is clear. The issue here is the aspect of “voluntary”. Euthanasia is euthanasia; it is defined. “Voluntary” means the person saying they want euthanasia. That is the distinguishing point here. That is not in dispute. In answer to an earlier question by the member for Darling Range, the minister made the point that the joint select committee and the ministerial expert panel had liaised with a lot of people. The minister said they had moved on from the term “euthanasia”. I asked how many people were communicated or liaised with through all of the processes that led to the bill being formed. How many people who opposed the bill agreed with the short title of the bill?

**Mr R.H. COOK:** I will ask the member to get back to his feet in a second just to clarify his last question. The member is quite right: we have a passion to ensure that members of the public understand that this is an entirely voluntary process. It underscores the technical nature of the bill and it underscores the principles and the value of the bill. In that context, the title reflects the approach and the outcome that we all aspire to.

In relation to the use of the term “voluntary assisted dying”, it is a term that is in common usage. It accurately describes what we are trying to do through this bill. In terms of people understanding what this is achieving in the context of other bills around the country, Victoria has the Voluntary Assisted Dying Act. The Western Australian bill has many similarities, so it is a perfectly appropriate title to use in that context. Could the member ask his final point again? I was not quite sure what the member meant.

**Mr S.K. L'ESTRANGE:** The point I am making is that the minister is making a lot about how this title is more appropriate. That is really what the minister is saying. The minister is saying that, in his view, this title is more appropriate than, for example, the title “Voluntary Euthanasia Bill”. The minister has defined euthanasia as being

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what it is. He is then saying this is voluntary, because obviously if it were not voluntary euthanasia, that would be akin to murder. “Voluntary” means that the patient has given their authorisation to participate in euthanasia. We get that. When the minister consulted the community prior to coming up with the short title of the bill, what term were the people who were opposed to the concept of euthanasia most comfortable with?

**Mr R.H. COOK:** Throughout this process, people have used a range of language. Voluntary assisted dying is the language that has been used most effectively to communicate with both those who support and those who oppose the bill.

**Mr S.K. L'ESTRANGE:** I will not labour this much longer, suffice to say that definitions are important. I do not think we should just assume that all the populace understands this term. That is particularly the case for people from multicultural and different language backgrounds. We have a set word such as “euthanasia”, which, as we have just heard from the member for Hillarys, has links to Ancient Greek times, and is defined as the intentional termination of the life of a person in order to relieve the person’s suffering. We understand the genesis of the word “euthanasia”. I do not understand why we should be frightened of that word. I think we should be honest about that word. If people choose “voluntary euthanasia”, that is their choice. That is what this Parliament has been debating for the last few days. That has not changed. I worry about the fact that the title may be picked up by a person who does not understand language as clearly as the minister does. As has been pointed out by some members, voluntary assisted dying for those at the end of life, in palliative care, is assisted dying. We know that. They are being assisted by expert staff to be cared for and made as comfortable as possible, and then they die. What we are providing in this bill is different from that. We are providing the opportunity for someone to take a lethal injection to end their life. That is very different from a palliative care approach. There seems to be a merging of what is assisted dying with what is euthanasia. That merging in itself may create confusion for people who might not be as well-read as the minister.

**Mr R.H. COOK:** I thank the member. I now understand what the member is saying. Certainly in our consultation process, the phrase “voluntary assisted dying” was in common usage and was readily understood by all the communities that we discussed it with. I understand the point the member is making, as indeed has also been made by the member for Riverton and the member for Hillarys. Voluntary assisted dying is a modern-day description of the process that is prescribed in the legislation, and I think it is entirely appropriate.

**Mr A. KRSTICEVIC:** I know that this legislation is currently in place in roughly a dozen jurisdictions. As the minister has said, Victoria is one of them. This sort of legislation around the world is pretty new. It has been around in some places for longer than it has been in others; however, it is relatively new in modern history. The minister is saying that this language is modern language. Can the minister tell me which of those 12 jurisdictions have the same title for their legislation; and, if they do not have the same title, what titles do those other 12 jurisdictions have for their pieces of legislation?

**Mr R.H. COOK:** No, I cannot, but I can assure the member that the Victorian legislation is titled in a similar way.

**Mr A. KRSTICEVIC:** The minister is saying that although we are the second state in Australia to debate this modern piece of legislation, he is not aware of the titles of the legislation in the other 10 jurisdictions in the world. I find it amazing that he does not know what the other legislation around the world is called or how it is referenced, yet he is saying that this is modern terminology. If this is modern terminology, one would assume that every other piece of legislation around the world that deals with this issue also refers to “voluntary assisted dying” and would not be called something that is antiquated or that people do not understand. I would expect the minister to know the titles of some of this other legislation. It is not good enough to refer to just the Victorian one, which has been introduced only recently. He should know the title of at least one other piece of legislation in the world, if there are so few of them, and why the title of our legislation is either the same or different. What makes us think that we have created this modern language?

**Mr R.H. COOK:** I thank the member for his long question, because it enabled me to locate the information that he is chasing. Victoria has the Voluntary Assisted Dying Act 2017. In Belgium, an act struck in 2002 is called the Act on Euthanasia. The provinces and territories of Canada have an “Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”. Quebec has the Act Respecting End-of-Life Care 2015. The detail on Colombia is not here, but I think its regime is found in common law. I will go through a couple of others that are more straightforward. Luxembourg has the Law of 16 March 2009 on euthanasia and assisted suicide. The Netherlands has the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. In Switzerland, there is no legislation that decriminalises assisted dying; it is a criminal offence to assist suicide only when the assister has a selfish motive, which is captured under its Criminal Code. In the United States, California has the End of Life Option Act; Colorado has the End-of-life Options Act; Columbia has the District of Columbia Death with Dignity Act; Hawaii has the Our Care, Our Choice Act; and Maine has the Death with

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Dignity Act. In Montana, it is done on the basis of common law. New Jersey has the Aid in Dying for the Terminally Ill Act; Oregon has the Oregon Death with Dignity Act; Vermont has the Patient Choice and Control at End of Life Act; and Washington has the Washington Death with Dignity Act. Just to summarise, only two of those jurisdictions refer to the word “euthanasia” and I think one of them was the Luxembourg legislation, which was struck in 2002. It is consistent with what I was saying. Modern acts tend not to rely upon the term “euthanasia” because, as I said, it has a range of meanings in a range of different jurisdictions nowadays.

**Mr A. KRSTICEVIC:** Of all the titles that the minister read out, a couple referred to “euthanasia” and some referred to “assisted suicide”; otherwise, the titles were generally all over the place. When the minister says that “voluntary assisted dying” is a modern term, is he saying that it is modern in the context of us making it modern in Western Australia and in Australia as opposed to modern on a world basis? I am trying to work out how he has come to the determination that this is modern terminology that has now taken over the world as the focus, as opposed to something that we have created in Australia.

**Mr R.H. COOK:** The point I am making is that it can be described in a range of ways to meet the needs of the community for which it is struck. In Australia, we have the Voluntary Assisted Dying Act in Victoria. It is the language we have used in the context of Western Australia, and I think it really aligns with the community’s expectations and views about these things.

**Mr A. KRSTICEVIC:** I will make just one last point and then I will leave it there. When the minister talks about the community’s expectations and views, again, like the member for Darling Range and, I am sure, many other members here, when people talk about this in my community, in my electorate, they talk about euthanasia. Nobody comes up to me and says, “Look, I want to talk to you about voluntary assisted dying”; they come up and say, “Look, I want to talk to you about euthanasia” or “I want to talk to you about assisted suicide.” The term “assisted suicide” would be used less often, obviously, but “euthanasia” is certainly used. I think the bill’s title is misleading. Yes, the ministerial expert panel and the people in the know may use this terminology, but it is not the community’s terminology. Yes, people may understand what voluntary assisted dying means because it is pretty obvious, but it is not the language that people I come across would normally use. I am trying to work out where the minister has got the view that this is the community’s language, beyond the expert panel and the people who were inside the tent who were using that language. What makes the minister assume that that is the case?

**Mr R.H. COOK:** I think it is language that everyone recognises. I commend the member for Carine to the second reading contribution of the member for Nedlands in terms of the outcomes of his community consultation. The term “voluntary assisted dying” also reflects the intent of the bill; that is, it is voluntary in nature and the patient has the right not to participate at any point. I understand that the member may have views that it is one thing but not the other, and he is right: people do come to this debate with a range of experiences and a range of ways of describing or naming it. I think “voluntary assisted dying” accurately reflects the intent of the bill and the framework that it prescribes.

**Mrs A.K. HAYDEN:** I do not want to push this any further than we have, except to say that I find it a little disappointing, because the community I represent in Darling Range—the people out there—do not refer to this as “assisted dying”; they call it “euthanasia”. I take offence at being told that this is modern terminology and this is what modern-day people, the people who are up to date with everything, use. I am telling the minister right now that people in Darling Range do not use that terminology. This legislation is meant to represent every single Western Australian, and particularly those who are vulnerable, not just those who are well-educated and learned and who live in Nedlands, with all due respect to the member for Nedlands. It is also about the people who live outside the western suburbs—who live in the eastern suburbs and regional WA. We need to make sure that when we are delivering legislation that is this important, people do not have any doubt about what it is about. How often are we blamed by the community for talking bureaucratic—I will not say the word—rubbish nonstop, yet here we are with a very important bill with a name that sugar-coats it, because for some reason, the minister is afraid to say the words “suicide” and “euthanasia”? Call it for what it is.

**Mr R.H. COOK:** I thank the member for that plea with regard to her local constituents. Obviously, I think it is important that we use language that is meaningful for people. Ultimately, I think people understand that voluntary assisted dying is just that; it is voluntary assisted dying. From that perspective, with the use of that particular descriptor, I think the member’s constituents would have a very clear idea of the intent and nature of the bill. I note that Palliative Care Australia now uses the term “voluntary assisted dying”. It is simply the language used to describe the modern context in which this legislation is struck and the intent of the legislation. As we have emphasised to the chamber time and again, this is an issue around a voluntary process—that someone voluntarily seeks to have control over the manner and timing of their death in the context of an inevitable, imminent and painful terminal condition. From that perspective, I think that people understand what we are trying to communicate when

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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we say “voluntary assisted dying”. Even with all due respect to the member for Nedlands’ constituents, I think people understand very clearly what we are describing here.

**Ms M.M. QUIRK:** The minister referred to the consultations that took place. It is true, is it not, that a number of questions were put to participants, but at that stage the decision to call it “voluntary assisted dying” had already been made, so it was not the subject of this community consultation that the minister referred to?

**Mr R.H. COOK:** As the member would be aware, the ministerial expert panel undertook a very extensive consultation process. I attended some of the consultations. People at those forums knew exactly what we were talking about when we used the language of voluntary assisted dying. I think it was very clear. We were also informed by the work of the Joint Select Committee on End of Life Choices. In that respect, I think the language in the title of the bill is absolutely appropriate.

**Ms M.M. QUIRK:** I am trying to confirm that at some stage between when the joint select committee met and when the consultation occurred, a decision was made that that is what the term would be. It was not the subject of any of the questions of the consultation panel, a number of questions of which are included in “Appendix 4: Consultation summary” of the expert panel’s report. There are no questions about what is the appropriate term. It is not a complicated question. I am just asking: is that the case? There was no debate on this; it was effectively decided already.

**Mr R.H. COOK:** I cannot vouch for whether it was already decided, but it is certainly true that we could not characterise the consultation process as a debate around the language about whether it was called one thing or the other.

**Mr S.K. L’ESTRANGE:** The member for Girrawheen has reinforced the point I made earlier—that is, when we are talking about the language of the short title of this bill, the minister made out that there was wide consultation. We have now discovered from the appendix included within the report that there was in actual fact no consultation on what the short title of the bill should read. It was called “voluntary assisted dying” and the government then went out and did its consultation on how a bill to support voluntary assisted dying should look. It did not go out and consult the community on how voluntary euthanasia should look. That is a very important point to make. I think that the minister should show a little more respect to the people who suggest that the use of words is important in such a serious bill, and just say, “You are correct. We didn’t consult on the name. We came up with the name and then we went out and consulted.” That would at least satisfy the record that that is what the government actually did. If I am wrong, the minister needs to provide some evidence to support his case that the government actually consulted on what the short title of this bill should be.

**Mr R.H. COOK:** As the member knows, the consultation process is not one of, “What do you think the short title of the bill should be?” The consultation process is informed by many conversations that are had over a period of time. We, as members of Parliament, are then informed by the reports that are informed by that consultation process. For instance, recommendation 24 of the joint select committee states —

The Western Australian Government develop and introduce legislation for voluntary assisted dying having regard to the recommended framework and following consultation with the Panel established under Recommendation 21.

The genesis of the use of the language “voluntary assisted dying” took place some time back in that long consultation process. We would not have done justice to the consultation process had we asked the question: did we poll people whom we consulted?

**Mr S.K. L’ESTRANGE:** I did not ask the minister whether anybody was polled, we are simply making the point that the short title of the bill does not reflect the correct use of language, which is what the bill is all about. That is the point we are making. In his answer earlier, the minister tried to make out that it is because of consultation that the short title of the bill was formed. We are saying that there is no evidence of that. The minister has decided it will be called “voluntary assisted dying” and then consulted with the community. Earlier I asked, “What about the people who oppose euthanasia? How do they feel about the title? Do they want euthanasia put in it?” I have not had that answered. Other members have asked different questions around the same topic, that there was not a consultation on the title of this bill. The government has created the title, which is a soft title, because it does not accurately reflect what the bill is about. We know perfectly well that when we use terms such as “voluntary assisted dying” it can be construed any number of ways, which is different from euthanasia, yet this bill is about euthanasia. The people who ask the question, “Why is that term not used in the short title of the bill?”, I think have every right to ask it, because it accurately reflects what the bill is about—that is, voluntary assisted euthanasia.

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**Mr R.H. COOK:** Member, we are informed by the consultation process, which made very clear the direction and the nature of this legislation. They want it to be voluntary and they want it to be issues around voluntary assisted dying. I am informed by the Lifeline WA position of 2013, which states —

Words can cause harm. Any linkage between euthanasia and suicide has the potential to cause harm.

We recommend that any public debate surrounding euthanasia refrains from making the link to suicide as this can provoke suicidal ideation

That is consistent with all the consultation processes that have gone on. The member says that he wants me to come up with a specific title that has been tested. The member knows that the process is not like that; it is one of a range of concepts, values and processes being consulted across the system. From that point of view, the ministerial expert panel was there to consult about safe and compassionate legislation and it recommended, amongst other things, this sort of language. It is the same language that is used in Victoria and it reflects much of what goes on in Victoria. I am not sure why people, regardless of their views about the legislation, would believe that it does anything other than just that.

**Mrs A.K. HAYDEN:** There are quite a few people in this room debating that the community is well aware of the term “euthanasia”. The minister has admitted that the modern terminology has come from all the community consultation and debate, yet we have now confirmed that the title of the bill was not up for consultation or debate. To ensure that there are no grey areas for the vulnerable and remote people of Western Australia who are not across the minister’s modern language and terminology, would the minister even consider, in good faith, renaming the bill by removing “assisted dying” and substituting it with “euthanasia and assisted suicide?”

**Mr R.H. COOK:** Respectfully member, no.

**Clause put and passed.**

**Clause 2: Commencement —**

**Mr Z.R.F. KIRKUP:** I understand as part of the minister’s second reading speech and again this evening in his summary, he has outlined to the house that there will be an 18-month implementation program, which I expect is captured as part of the commencement clause. Can the minister walk us through what the process and implementation of part 1 and the remaining divisions by proclamation of the bill will look like? I note that the minister has used some slight variance about the 18 months, and I appreciate that it might take a longer or shorter time. Does the minister have an understanding about what that implementation phase will look like, and from the minister’s perspective, is there an absolute minimum for the implementation of the remainder of the act, which I assume it will become at that fixed date according to proclamation?

**Mr R.H. COOK:** We anticipate that the proclamation date will be 18 months from the date of passage of the bill so that health services in the community can prepare for the changes. Obviously, a lot of regulations need to be put in place and, in particular, the Voluntary Assisted Dying Board will have to be constituted. We will require the establishment of a suite of new procedures to enable the scheme to be implemented properly, including the establishment of the board. In particular, it will require the establishment of the training process and the Royal Australian College of General Practitioners to ensure that it meets all its accreditation requirements. The ministerial expert panel recommended the 18 months and certainly our health colleagues in Victoria have anecdotally advised that a minimum of 18 months will be required for the implementation period. We have some advantages over Victoria, because we can learn from some of the things it has already done. We have some disadvantages because we have a different landscape both medically and geographically, so we need a regime that fits across those things. It is considered that 18 months is really the bare minimum we need to help with that process.

**Mr Z.R.F. KIRKUP:** To confirm, the absolute minimum would be 18 months in that case. I appreciate the language the minister has been using thus far about it being approximately 18 months. Even if the health services were very well advanced and were comfortable with implementation 12 months from assent, would we still see a proclamation stage in 18 months?

**Mr R.H. COOK:** That is correct.

**Ms M.M. QUIRK:** Minister, given that we are contemplating an 18-month implementation period, I wonder why we are hastening it through at this stage.

**Mr R.H. COOK:** Does the member mean the haste in terms of —

**Ms M.M. Quirk:** I mean in passing this bill now.

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**Mr R.H. COOK:** Obviously, there is a range of issues in relation to that, but as the member has just observed and I have just stated, our Victorian counterparts have advised that a minimum of 18 months will be required for implementation. Clearly, we need to make sure that we get that process going. The passage of the bill will ensure that we have things in place as soon as possible. The community has been clear that there has been a need to go beyond palliative care services and provide Western Australians with the genuine choice that they require to experience fulfilling lives and respectful deaths. The 18 months will provide for the proper implementation of the processes and other measures, such as the establishment of the board. Clearly, the sooner we can pass this bill, the sooner they can get on with that work.

**Ms M.M. QUIRK:** Another issue I want to raise with the minister in this context is that when we had a very helpful briefing from various advisers, they contemplated that there would not be extensive regulations, which the minister seems to have suggested now, and that a lot of these issues could be handled administratively. We see peppered throughout the legislation “the CEO will do this” and “the CEO will approve that” and so forth. They are all indications that matters will be handled administratively and, I would have thought, that could also be done for training. I am curious to know what the minister contemplates, other than the setting up of the board. What else will be the content of the regulations?

**Mr R.H. COOK:** I perhaps used the word “regulations” too broadly, so I apologise for that. The bill does not require any regulations to be made in that context. The bill has been drafted as a comprehensive piece of legislation to operate as is. There is a general regulation-making cause as a futureproofing mechanism; however, it is not anticipated that there will be any regulations made under this bill. In particular, the member should understand that each of the processes is required to be noted in relation to certifiable forms. The CEO has a responsibility to specify the nature of the information provided to the patient. We will have a lot of work to do to not only establish the Voluntary Assisted Dying Board, but also make sure that we have the necessary training in place, and, as I said, we are very determined to make sure that that training package is comprehensive. I think there is other important work that needs to be done and that is to make sure that there is public awareness of the legislation once it comes into effect. The member for Darling Range has already voiced her concerns about community understanding and awareness of the nature of the bill, and that is an important part of it. Other measures that the CEO has to approve include the list of voluntary assisted dying medication and further criteria for medical practitioners. Once we have decided what the further criteria are, we can design training program. It is a pretty comprehensive process and from that point of view, we can well understand that 18 months is very valuable time to get things in place.

**Ms M.M. QUIRK:** Member for Riverton, this is it for me. Can I confirm that part of the 18 months is not going to be because it is anticipated there will be a raft of regulations that need to be drafted and that most of the filling out in this legislation will be done administratively?

**Mr R.H. COOK:** Yes, member.

**Dr M.D. NAHAN:** One of the issues that has been raised with me about the bill is why it is coming in so quickly and why we have not spent more time learning from the Victorian legislation that just came into place. Did the minister put effort into learning from the Victorian legislation? It just came into action. I think there has just been a handful of applicants, and one person has followed through. In the next 18 months while this administrative process is being gone through, will there still be an eye kept on the lessons learnt, if any, from Victoria, particularly on some of the definitions that we are dealing with now to do with risks and addressing coercion, what is voluntary and when people can make a conscious voluntary action? Will the minister give a commitment to this place that he will monitor what is going on in Victoria? I am sure that Victoria has various types of processes to assess what happens.

**Mr R.H. COOK:** I advise that the ministerial expert panel and the Department of Health had extensive consultations with the Victorian Department of Health and Human Services and also the thinking of other jurisdictions in relation to this. As I said, the Department of Health has spent some time with the Victorians and is already learning from a lot of the implementation processes Victoria went through, which, as the member would appreciate, is a key aspect of what needs to be put in place and anticipated. Certainly, we will continue to monitor that situation and work with the Victorians to learn from their experiences.

**Dr M.D. NAHAN:** The minister mentioned that Victoria advised of the minimum period of 18 months. Given the geographic reach of our state relative to Victoria and, I have to say, the diversity of communities, does the minister not think it will take longer to put this type of legislation in place in WA than Victoria?

**Mr R.H. COOK:** I think we will learn a lot from Victoria, particularly with the training packages. We can look at what it does, borrow some of that curriculum and utilise some of the stuff out of that. In that aspect, we will be able to move fairly swiftly. The member is right: we have our own unique challenges. From that point of view, they will present a unique set of challenges for us to overcome. But we are advised by the Victorians and those

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who are closer to this process that 18 months is, on balance, what we will probably need to get everything in place, even with the learnings from Victoria.

**Dr M.D. NAHAN:** One of the issues raised by the members for Dawesville and Kimberley is the unique and special nature of some of our Aboriginal communities. They do not exist in large numbers in Victoria. Would the minister have a special program to address those? I think the problems that were brought up around those issues are quite profound and require special focus in terms of implementation.

**Mr R.H. COOK:** Member, I think that is certainly the case. The expert panel has obviously itself had the opportunity to be informed by extensive consultations with the Aboriginal community. We will obviously take the opportunity to make sure that we continue to work with all the stakeholders on this. That includes not only people from the culturally and linguistically diverse communities, but also community stakeholders such as the WA Primary Health Alliance, the Australian College of Rural and Remote Medicine, the WA Country Health Service and the Australian College of Nurse Practitioners. We will continue to need to talk to a range of people in order to make sure that we have a good understanding about the needs of not only the people in the community, but also the people delivering the service.

**Ms M.J. DAVIES:** I have a question about the interaction of the bill with the commonwealth Criminal Code, which is something I foreshadowed in my contribution to the second reading debate, and whether or not we will have clarity around any of the implications for face-to-face interactions with doctors and patients or health professionals and patients before the commencement of the bill. We have expressed concern about this issue, particularly around access to voluntary assisted dying in regional communities where we utilise telehealth and teleconferencing, and I imagine that will be canvassed as part of the implementation process. Commonwealth legislation has certainly raised some concerns in the Victorian jurisdiction, and from a Western Australian point of view, we would be seeking clarity before the commencement of the bill.

**Mr R.H. COOK:** Yes. I did speak fairly extensively on this at the conclusion of my summary of the second reading debate. As I mentioned, there are a range of reasons that we believe that it is not in contravention of the commonwealth Criminal Code. As I reported, not only has the Department of Health been in contact with the commonwealth, but also the Attorney General has been in communication with the commonwealth Attorney-General, so we will certainly know before the expiry of the implementation period exactly where we stand on that. I am pretty confident that we will be able to resolve those issues. If not, we will do it the good old-fashioned way and make sure that it works.

**Mr V.A. CATANIA:** Further to the issue raised by the member for Central Wheatbelt, can the minister clarify what steps he has taken in talking to the commonwealth prior to introducing this legislation? I think it is a pretty major issue that needs to be resolved prior to the commencement of the legislation. It could affect the whole legislation if the commonwealth does not agree with the government's reading of and reasoning why it should not come under the commonwealth act, or its interpretation of the commonwealth act. Can the minister elaborate a little more, given that it will play a major role in how this legislation may perform if it gets through both houses of the Parliament of Western Australia and gets royal assent?

**Mr R.H. COOK:** Member, nothing will stop us from implementing the bill. It hinges around one specific aspect, and that is the use of a carriage service in relation to the commonwealth Criminal Code Act 1995. As I said in my response to the second reading contributions, two sections of that act deal with the issue of controlling, producing, supplying or obtaining suicide-related material or using a carriage service for suicide-related material that directly or indirectly counsels or incites committing or attempting to commit suicide. The sections of the commonwealth Criminal Code Act are specifically about those issues. The member for North West Central will remember that it was legislated because of websites that promote suicide or cyberbullying in that context. Certainly the advice we have is that it will not be an impediment to our legislation. Our legislation also explicitly states that this is not suicide, which is not part of the Victorian legislation.

There has been some preliminary communication between the Department of Health and the commonwealth Attorney-General's Department. The government is consulting with the commonwealth to ascertain its position with a view to seeking an undertaking that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to make it clear that the provisions do not apply to voluntary assisted dying. However, absent an undertaking from the commonwealth, a legislative amendment of the relevant provisions of the Criminal Code Act or a decision of the court, we acknowledge that there may be uncertainty about whether communications about voluntary assisted dying over a carriage service will contravene the commonwealth legislation. The advice we have is that it will not or that it can be resolved amicably with the commonwealth. Having said that, it will not ultimately impact upon the commencement of the bill but it will potentially impact that section of the legislation.

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**Mr V.A. CATANIA:** When did the minister's department make contact with its federal counterparts or the Attorney-General's office? Was it prior to the bill being introduced or in recent times? Has the minister written a letter to the commonwealth Attorney-General seeking that clarification; and, if so, when did the minister write to the Attorney-General? It is important that we ascertain this because if it was only yesterday, obviously the minister will not get a response for a while and it could play a large role in perhaps being the downfall of the bill if it is seen to be in breach of federal laws.

**Mr R.H. COOK:** I am advised that the Victorian legislation was identified as having some difficulties in relation to that act in early June. Conversations have been taking place since then. I cannot provide the member with the details but I am happy to get them to the member. I have not written to the Attorney-General. The Attorney General has written to the federal Attorney-General, as we would expect, but it is not something that I have undertaken.

**Mr V.A. CATANIA:** The minister said that our Attorney General has written to the federal Attorney-General. Does he know when the Attorney General wrote to the federal Attorney-General to seek clarification?

**Mr R.H. COOK:** I do not have that information for the member, but I am happy to get it for him. I think we will be doing this for a little while so there is plenty of time to get back to the member.

**Ms M.M. QUIRK:** The minister referred to having received advice on this issue. Who provided that advice?

**Mr R.H. COOK:** My advisers, member.

**Ms M.M. QUIRK:** From that I take it the advice was provided by people within the department and there was not a separate counsel's opinion or State Solicitor's opinion.

**Mr R.H. COOK:** I am advised that the Solicitor-General and the Department of Justice provided that advice.

**Mrs A.K. HAYDEN:** I refer to clause 2(b). Why do clauses 14 to 184 require delay? That is a massive amount of clauses, considering that there are only about 180-odd clauses in this bill. Can the minister explain why clauses 14 to 184 need to be delayed?

**Mr R.H. COOK:** Those clauses deal with the substantive aspects of the bill, so are subject to the implementation period.

**Mrs A.K. HAYDEN:** Just to clarify—does every single clause from 14 to 184 come under the explanation the minister has just given?

**Mr R.H. COOK:** Yes. They have to do with the details of the legislation, including training and things of that nature. That is why they are subject to the implementation period.

**Clause put and passed.**

**Clause 3 put and passed.**

**Clause 4: Principles —**

**Mr Z.R.F. KIRKUP:** Clause 4(1) lists a range of principles people must have regard to under the act. I am keen to understand how those principles will bind anyone who participates, either as a participant, a patient or anything like that, to the act. The language used is that they must "have regard to" the principles that are laid out. What legal implication will that have? What mechanisms will be in place to enforce the relationship that a patient or a practitioner might have with those principles? What does "have regard to" mean in practicality?

**Mr R.H. COOK:** The principles will serve as a guide to interpreting and applying the act in relation to those matters. They will not create any new obligations. The principles were recommended by the ministerial expert panel. As the member can see, they are cast widely and underpin the values and principles of the bill.

**Mr Z.R.F. KIRKUP:** I refer to the language "must have regard to". I appreciate that a range of very extensive principles have been taken from the expert panel. Some of them are quite esoteric and quite well-meaning. What will the practicality be if someone does not have regard to them? I suppose it will not mean a whole lot for people who disregard them. Can the minister confirm that there will be no legal implication if people do not have regard to any principle listed? I am assuming that this is the intent and that the government is hopeful that people will follow the principles enshrined there, but there will be nothing that will bind them to do that and no penalty if people do not have regard to elements (a) to (j) of those principles. Could the minister walk me through that process a bit more? I would appreciate that.

**Mr R.H. COOK:** It is consistent with legislative drafting practices; that is, when someone, particularly in a judicial role, is trying to understand the intent of the legislation, potentially when the member and I have left this place, they will go back to the legislation to work out the intent of the legislators at the time and can go back to the principles to understand and interpret it. In a judicial or regulatory situation, they would look at the principles of the legislation to understand what we were trying to achieve.

**Extract from Hansard**

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**Mr Z.R.F. KIRKUP:** I thank the minister very much for that. How much of this binds the government as well as part of its own health policy? I note there are a number of references there. Specifically, for example, clause 4(1)(d) provides that people should have access to high-quality care and treatment, including palliative care options, and clause 4(1)(h) provides that a person is entitled to genuine choices about their care, treatment and end of life, irrespective of where they live in Western Australia, and having regard to their culture and language. How many of these principles apply to the government in terms of its own health policy settings as they apply to end of life?

**Mr R.H. COOK:** It is certainly binding on the Crown, but there is no penalty involved in it as such. Obviously, we would have regard to the fact that the government's obligation, like everyone else's obligation, is to observe those principles as well. In that context, it is obviously an aspect of the bill that really underpins those principles. The government, like every other entity in the community, is caught within those.

**Mr Z.R.F. KIRKUP:** I thank the minister. Paragraph (d) is an area of concern for me. That principle states that the person must have access to high-quality care and treatment, including palliative care options. A number of members in this place have spoken about the lack of palliative care options in the regions. In particular, I have spoken about impacts on regional and remote Aboriginal communities and the lack of culturally appropriate palliative care in those areas. I am interested to know what that might look like, given that we are enshrining this as a principle of the legislation. People might not actually have access to high-quality palliative care. There is obviously a lot of merit in any government wanting to see the option for a patient to have access to high-quality palliative care, and I appreciate that that has been included as part of the principles, but what happens when there is an obvious failing in that respect? As we have spoken about a number of times, including in the minister's reply to the second reading debate, there is identified inequity with regard to regions and socioeconomic demographics, particularly with Aboriginal communities. What happens in areas where the government is clearly failing? The principles are there. How can we make sure that the government follows through on those principles to ensure that there is high-quality care and treatment, including palliative care, for all people, wherever they are in the state?

**Mr R.H. COOK:** I thank the member. There is no penalty associated with the principles as such, but from that point of view, the government would be informed by the principles, like anyone else. For example, the end-of-life and palliative care strategy that is currently being crafted under the 2018–2028 strategy process will have regard to the principles that are part of this bill because they should inform general government policy. From that perspective, it will inform and mould the policy framework within which the government operates.

**Mr V.A. CATANIA:** The member for Dawesville obviously raises a very good point. As the minister said, the government must adhere to the principles. It is all well and good adhering to the principles, but the legislation highlights that every person has the right to be able to receive palliative care. As I said in my contribution to the second reading debate, in regional Western Australia it is very difficult to access palliative care, particularly in the north west; I do not think there is anywhere in the north west where people can access palliative care and, therefore, they are being pushed out. Clearly, it is all very well and good that the government has set out these principles, but regional Western Australia needs financial backing to be able to get the palliative care it actually needs to fulfil the principles the government has set out in clause 4. Clause 4 clearly provides that the government needs to be able to adhere to its own principles and to deliver the opportunity for people to be able to receive palliative care. I take that as being in the town in which they live or close to the town where they live; not saying, "Yes, you can access palliative care, but if you live in the Kimberley, the Pilbara, the Gascoyne or the midwest, how about you head down to Perth to receive that palliative care treatment?" We all know that is not feasible in a lot of ways. People do not have the resources to do that or the ability to find out how to go about receiving palliative care. Often, there may not be a doctor, or a nurse practitioner at the very least, to be able to explain that. People rely on those trips—whether they can afford them or not or whether they get assistance from the patient assisted travel scheme—to go to a major town or city that can provide that care and also to be educated about their choices in palliative care and the treatment they could receive. It is all very well to have principles, but how will the government back up its principles with the amount of money that is needed to put palliative care in regional WA, which is currently non-existent?

**Mr R.H. COOK:** I appreciate the comments the member made. The member and I have had many discussions about the opportunities that someone has to access health care in Carnarvon generally. One of the member's constituents once came to me, before we were in government, because he was struggling to get dental care in Carnarvon. It is a challenge in regional communities, as is any health service. This bill envisages a situation in which people do not make a choice between palliative care and accessing the functions of this bill. That is not the intent. It is about setting out the principles with which the government should have intent in terms of the overall ecosystem that people work in. This does not give rise to litigation, if that is the point the member wanted to make, but it does say that people should have access to quality palliative care. In that context, I guess actions speak louder than words.

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That is why we have had that significant increase in palliative care funding, particularly in the regions. For instance, in the north west, where rural palliative care teams have coverage in areas such as the member's, we will be able to boost those services so they do have the outreach that people need.

**Mr V.A. CATANIA:** I understand the minister's explanation, but I suppose what I find difficult is the minister says there are principles the government would like to adhere to—we hope that all governments would adhere to these principles—but the reality is something different. To me, this seems like more of a motherhood statement saying, “She'll be right, we'll provide that support and opportunity to receive palliative care”, but in reality it is just not there. The reality is it is just not in the government's budget. That is the issue that a lot of people have. I said, and I think the member for Warren–Blackwood also said, that the two are different—voluntary assisted dying and palliative care. Palliative care is in the bill as one of the principles. As I said, it is more of a motherhood statement. To gain the confidence of people in the other place perhaps, is there a way the government can back up these principles so they are not motherhood statements? Is the government able to offer some serious financial backing to people in regional WA, and people anywhere in Western Australia, so they have the opportunity to receive palliative care, rather than saying it is a principle and basically a motherhood statement? In my view, we need to solve the palliative care crisis. The government's financial pocket is lagging behind its principles.

**Mr R.H. COOK:** I thank the member. I take the member's counsel in relation to how we might deal with the other place, and I thank him for his input. I guess our pockets are deeper than they have ever been, with over \$206 million for palliative care across the forward estimates, of which almost \$60 million is dedicated to regional palliative care services. The member has said, quite rightly, that more needs to be done. We can always do more, and we have plans to do more, but we have to work with what we have. The member describes the principles as motherhood statements. They are principles. They are not prescriptions. They are principles that we want to see observed to inform the approach to the bill. I take the member's point that he might consider them to be motherhood statements, and in some respects they are. They are principles that will bring to the process without necessarily being a prescription about services.

**Mrs L.M. HARVEY:** I refer to clause 4, “Principles”, in particular subclause (1)(d), which states —

A person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life;

I am interested to know why the minister has used the word “should” be provided with care, rather than “must” be provided with care. The word “should” is more about a recommendation or a desirable goal. It does not really compel action. The word “must” brings with it an obligation for action. I am curious to know why the minister has chosen “should” over “must”.

**Mr R.H. COOK:** I guess it is because they are principles. They describe intent, rather than prescribe action. I understand that the point the Leader of the Opposition is making is that she would want everyone to be given high quality care and treatment, including palliative care. I certainly agree with the sentiment that the Leader of the Opposition is reflecting. However, this is consistent with drafting practices. This is about the principles or the intent that we are bringing to the process and that underpin the values that sit within the bill.

**Mr T.J. HEALY:** My question relates to clause 4(1)(g), which states —

A person should be supported in conversations with the person's health practitioners, family and carers and community about treatment and care preferences;

We have spoken about this briefly. This question has been raised by a few of my constituents, and I want to get it on the record. I am in favour of the bill. However, I would like to get some clarification. People die. People get hit by cars. People have heart attacks. We have a mourning process within our society that deals with that. I want to talk about the ripple effects for a family that is involved in administering the final part of this process. I have reflected on the fact that my mother might be eligible for voluntary assisted dying and might say that she would like to go down this path. This is not something I would ever want to do, but I know it is one of the scenarios. My mother might say that she would like us to administer it, and we sit together as a family and decide to do that. I am not sure I have the right word for it, but, if that were to happen, my family would be far more involved in the death of that person than if they had died from a heart attack or in a car crash or from something else. I am not after a \$10 million figure. I just want to put this on the record. Has any consideration been given to where we might be in five years or 10 years when a number of patients and a number of families have had a more intense level of involvement with the death of a loved one? Could the minister give some commentary on that?

**Mr R.H. COOK:** I thank the member. He has touched upon some very important issues, particularly around the interaction of family with the person involved. The intent of this bill is to place that person at the centre of the decision-making in a voluntary nature, with the empowering nature of it. Just to come to one aspect of it—we can

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come to it later on the specific clause of the bill—the family would not administer the substance in that context. The bill enables administration only by a practitioner or the patient. The member for Southern River's mother could not say, "Terry, could you take care of this for me?" The bill does not allow for that. Obviously, a medical practitioner has many years of training on the patient–medical practitioner relationship. The conversation about end-of-life choices would be a very long one and would inevitably involve the family members and supporters and carers of the person involved. I do not want people to characterise this as, or get the impression that this is about, a quick conversation that would happen by the bedside, with the medical practitioner scurrying out to fill out forms. This is obviously a very considered and careful process, and understandably the family would be quite involved in that process. From that perspective, bereavement support could be provided to family members to make sure that they were also supported in the process. As many members have observed, end of life is a difficult process. I read with interest the experience of Kerry Robertson, who was the first patient to access voluntary assisted dying in Victoria. Her daughters talked about being intimately involved in the lead-up to the process and sitting with her when she took the voluntary assisted dying substance. By its very nature and by the nature of love, support and care that someone receives, this will involve families. I hope that answers some of the member's issues.

**Dr D.J. HONEY:** The minister referred a little while ago to the \$206 million for palliative care over the forward estimates, which I assume includes a four-year period. Is there any comparative estimate of the cost of the voluntary assisted dying process once it is up and running? I appreciate that we will go through an initial period of getting it up and running, but there will be costs for the board and board members, administrative procedures and the medication and for providing other services in regional areas. Does the minister have an estimate of that, please? It is just to give a comparison and to contextualise the estimated expenditure on palliative care over that period.

**Mr R.H. COOK:** It is a difficult question, but I thank the member for it and understand his intent. Perhaps by way of another explanation, in looking at the Victorian legislation, Victoria has committed \$6.35 million per annum in the 2018–19 budget. Obviously, Victoria has a bigger population, so it has more people to manage in that process, but it has a smaller jurisdiction so there is less cost associated with travel. I hope that gives the member some handle on the sorts of numbers we are looking at. Obviously, we will have to be informed during the implementation phase about the ultimate budget for the legislation as we discover where the costs lie.

**Dr D.J. HONEY:** I appreciate that it is a little bit intangible at the moment, but would it be in the order of no more than \$10 million? Would that be a fair question?

**Mr R.H. COOK:** I was about to say that the member cannot quote me, but of course he can because it is in *Hansard*. Yes, that seems to be the sort of ballpark that we are looking at.

**Mr R.S. LOVE:** Clause 4(2) states —

... reference to a person exercising a power or performing a function under this Act includes the Tribunal exercising its review jurisdiction in relation to a decision made under this Act.

Could the minister explain what that will mean in practice? For instance, if someone cannot necessarily access palliative care, how can that change the interpretation or a decision by the State Administrative Tribunal? I really do not understand what this clause means and I beg the minister to explain it.

**Mr R.H. COOK:** Member, we will have an opportunity to dig into the role of the State Administrative Tribunal under the clause that relates to it. However, subclause (2) suggests that essentially when the tribunal exercises its review functions under the act and makes decisions, it must respect the principles of the decisions that it has made. For instance, it might come down to whether someone has a decision-making capacity and, let us say, someone appeals against that process. The SAT must sit down and think, "What is the basis upon which we should make our decision?" Obviously, it refers to the technically prescriptive aspect of the legislation, but it will also be informed by the principles that underpin the legislation.

**Mr R.S. LOVE:** I take it—I do not know for sure—that given that many health services are provided by the state, the state is also expected to abide by the principles outlined in the bill. Therefore, when the SAT makes decisions about a particular matter, is there a power, or an expectation—to some degree, a rectification—if some principles are not met? For instance, if a person in the Kimberley is reviewed and it is found that there is no adequate palliative care for that person in the Kimberley, can the SAT order the state to provide it?

**Mr R.H. COOK:** The tribunal has specific roles under this legislation. Someone cannot go to the tribunal, for instance, and say that this principle says this, but they are not getting that, so the tribunal should make a decision about the allocation of resources or the provision of a service. However, it will allow the tribunal to make decisions in those areas that it does have responsibility for. Let us say we are talking about advice a person has received from a medical practitioner. It would be consistent with the bill and its principles that the tribunal could cross-examine

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a medical practitioner and ask them whether they have informed that person about the availability of palliative care services, or something of that nature—being informed by the principles in this particular aspect. I think the member might be at the same point that the member for North West Central got to. The principles do not give rise to litigation, but in terms of working with the act, it informs those making decisions, particularly in a judicial context, about what the bill is trying to deliver.

**Mr P.A. KATSAMBANIS:** I have a number of questions on this clause, but since we are discussing subclause (2), I will ask the minister about that. The minister has explained that the principles to which any person exercising a power or performing a function under the act will have to have regard will apply equally to the tribunal when it exercises its review jurisdiction in a decision made under the act. I seek clarification from the minister whether, after the tribunal makes a review decision and it is appealed to a higher body—in a court—that appeal body will also be subject to the principles outlined in this clause. If that is the case, how will that operate under this legislation, given that there is no specific power for the court to have regard to any of those principles?

**Mr R.H. COOK:** I understand that the answer to the member's first question is yes. Obviously, someone can appeal a State Administrative Tribunal decision. The member would know this better than I, having a legal background, but I understand that the process is that it is then taken to the Court of Appeal. All those issues sit within the State Administrative Tribunal Act 2004, as such, so we do not need to spell out those appeal processes in this bill.

**Mr P.A. KATSAMBANIS:** That was not my question. My question was that when someone goes to SAT under this bill, for any purpose—we will get to that—the member of SAT presiding over this review has to have regard to these principles. That is all well and good; that is fine, and we accept that. After SAT has made its decision, if one of the parties is not happy with the decision and appeals to a higher authority, to a court, will that court have to have regard to these principles in making its decision? If so, how will that operate, given that there is no specific reference to a court or any appeal powers from SAT in this clause?

**Mr R.H. COOK:** I guess it will depend on the nature of the appeal, but, from my understanding, a person can appeal a decision of the State Administrative Tribunal only on a point of law. From that perspective, they would not be referring back to the original legislation. I am happy for the member to guide us in that process, but my understanding is that if a person is unsatisfied with the decision of the State Administrative Tribunal, they would be appealing against the way in which that tribunal made its decision and whether that was consistent with tribunal processes, not going back to the original legislation. They would be appealing on the point of law.

**Mr P.A. KATSAMBANIS:** But the point of law may relate to the decision that the tribunal has made. That is the point here—that to appeal a point of law, a person is effectively appealing the decision made by the tribunal in interpreting the law, which is contained partly, and in this case almost wholly, in this legislation. Again, I ask my question: whenever an appeal lies beyond SAT, beyond the tribunal, will the court hearing that appeal be bound to take these principles into account or will there simply be some sort of best regard references that have no force or probative value in law?

**Mr R.H. COOK:** The advice I have in relation to that is yes.

**Mr P.A. KATSAMBANIS:** Sorry, my question was either/or. Will they or will they not? I just want to clarify. Will the court be bound to apply these principles in making any decision that lies on an appeal from a decision in SAT?

**Mr R.H. COOK:** Yes, member.

**Mr P.A. KATSAMBANIS:** I return to clause 4(1). The minister has stressed that these are simply principles. If someone who is exercising a power or performing a function under this act does not give regard to these principles, what remedy is available to the person who feels aggrieved by that person not having regard to these principles in exercising their power or performing their function?

**Mr R.H. COOK:** First of all, obviously, the person would have to have standing with regard to taking the issue to the State Administrative Tribunal, but, ultimately, the State Administrative Tribunal would make a decision on the basis of the decisions it is required to make. It would be informed but not bound by these principles, as is consistent with the nature of principles.

**Mr P.A. KATSAMBANIS:** I think that has given us some insight into the fact that this is just a wish list, but irrespective of that, I hope that in practice someone will give some regard to them. There are a number of principles and some of them have been articulated around palliative care. I share the concerns raised by members around palliative care. A number of us, including me, raised it in our second reading contributions. Clause 4(1)(i) states —

there is a need to protect persons who may be subject to abuse;

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I want to clarify what that means. I note that the next clause is a rather lengthy definitions clause that does not define the term “abuse” in any way. Can the minister enlighten us about what abuse it is envisaged a person will need to be protected from under this regime?

**Mr R.H. COOK:** That comes down to what would be considered abuse in the ordinary use of the language. Abuse can be physical abuse, sexual abuse, financial abuse or emotional abuse. This is part and parcel of one of the key principles of the legislation; no-one who would be accessing voluntary assisted dying is in any way subject to abuse. From that point of view, I am not quite sure why the member has difficulties with that provision being in there or why he wants the meaning of “abuse” prescribed. I think it means abuse in the broader sense of the word.

**Mr P.A. KATSAMBANIS:** “Abuse” is quite a strong term. There are a number of concerns about people’s influence on patients’ decisions, such as coercion, duress, undue influence and the like. A lot of those terms have specific legal meaning, which is not defined by reference to the word “abuse”. I am not aware of any legislative provision in Western Australia or any precedent that defines coercion or duress as abuse. I am simply concerned about where the boundary will be drawn for what constitutes abuse and what is considered bad behaviour that may not necessarily reach the point of being abuse. In asking that question, I seriously ask the minister to contemplate broadening this definition, because, as I said, abuse has quite a high bar to go over to be proven. Alternatively, I suggest an inclusive definition that says something along the lines of “abuse includes duress, coercion and undue influence”. Otherwise, irrespective of whether these are principles or enforceable legislative provisions, we leave this act open to question marks about serious matters that could have strong influence on a person who is contemplating making these sorts of decisions that may not necessarily reach the point of being considered abuse but would still be considered to be having an unfair and undue influence on that individual.

**Mr R.H. COOK:** I acknowledge the member’s concerns about abuse, but I think in the context of the principles of the bill this is not considered a binding or prosecutable aspect. It is about the principle of it in the broadest possible terms. It has been brought to my attention that this is the very same wording that has been used in Victoria, and ultimately this would be what it says; that is, we do not want someone to be subject to abuse. It does not say “a level of abuse” and it does not say “a type of abuse”; it is about the concept that a person is subject to abuse. We want that to be considered an important aspect of the principles of legislation and what is being brought to the process through it.

**Mr P.A. KATSAMBANIS:** We all agree that no-one wants anyone to be subject to abuse, but the point here is that there are levels of pernicious behaviour towards a vulnerable individual that may not necessarily be considered to be abuse; they may be considered to be slightly lower than the benchmark for abuse, but still highly influential and pejoratively influential on an individual. That is the point I am making. I have made it very clear that I do not feel comfortable supporting this legislation, but I still want it to be as safe as humanly possible. I think that limiting the types of influences that a person is protected from to abuse is setting the benchmark way too high, because, as I said, I know of no legal jurisdiction that defines duress as being abuse or that defines coercion as being abuse. If it is litigated, there may well be a finding that there needs to be a level of coercion or duress before it is abuse. We are talking about principles here and I would have thought that broader and more inclusive language would have been used to assuage the fears and concerns of people, which I have, that this is highly prescriptive and highly dangerous legislation that does not provide enough protection for vulnerable individuals. I will leave my concerns at that.

**Mr R.H. COOK:** I thank the member and I appreciate his comments.

**Mrs L.M. HARVEY:** Clause 4(1)(e) states —

a therapeutic relationship between a person and the person’s health practitioner should, wherever possible, be supported and maintained;

Why is this in the bill?

**Mr R.H. COOK:** It was a clause recommended by the panel. It is about the enduring relationship between the practitioner and the patient. It is also in the Victorian bill.

**Mrs L.M. HARVEY:** I am curious to know why that needs to be a principle. Is it anticipated that there is going to be an interruption to the therapeutic relationship as a result of this legislation? Why does that need to be there? I find it really curious. It sounds as though there is an expectation that somehow through these discussions, the therapeutic relationship between the practitioner and the patient may potentially break down in some way. I just do not know what is anticipated and why this should be in the bill as a principle.

**Mr R.H. COOK:** Again, member, the principles are about the values that underpin the legislation. In particular, what we are trying to emphasise here is the importance of the health practitioner and the person’s relationship. We all understand that a strong, long-term, intimate therapeutic relationship is good for both the health practitioner and the person involved. We typically see that in a GP–patient relationship. However, obviously, there will be times when

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that relationship cannot be maintained, for reasons of conscientious objection or something of that nature. This is stating that we believe that relationship is an important one and should be supported wherever possible in the context of this legislation, because we know that the strength of that relationship produces good outcomes.

**Ms M.M. QUIRK:** I have a couple of queries on this clause. One follows on from the queries of the member for Southern River on proposed clause 4(1)(g), which states —

a person should be supported in conversations with the person's health practitioners, family and carers and community about treatment and care preferences;

Conversely, an individual can choose not to have a conversation with any of those people, for example, in the case where there is a family dysfunction; is that correct?

**Mr R.H. COOK:** Yes, that is right.

**Ms M.M. QUIRK:** The other issue relates to autonomy. A definition would probably be helpful; that is not in the act. That is contained in clause 4(1)(b). Would you agree with the proposition that autonomy is an absolute? There are many areas and many laws that limit autonomy. For example, I do not have the autonomy to sit in a car and not wear a seatbelt, or to ride a bike but not wear a bike helmet. There are limits to people's autonomy.

**Mr R.H. COOK:** Yes, there are limits to autonomy; that is correct. This is enunciating, I guess, the principles or the values that underpin that person making their end-of-life choices. We want them to make those choices unshackled, in some respects, to make sure that they are able to make that decision freely. Their agency in that process is obviously important. I guess that is why it alludes to autonomy being an important principle.

**Dr D.J. HONEY:** Minister, I want to come back to the point that was being explored by the member for Hillarys—that is, under 4(1)(i), the need to protect persons who may be subject to abuse. I spoke to a large number of people about this bill and a large number of lawyers. Every lawyer I spoke to expressed their immediate concern on the issue of undue influence. Undue influence can occur all the way from what would be legally described as abuse—that is, someone who is threatening or intimidating or very overtly bullying someone—to someone who is loving and caring and otherwise has a positive relationship with the patient, but seeks to influence them. As I said, it could be out of love. There is an enormous body of case law around undue influence and coercion, particularly undue influence, which goes to a conflict when someone may have a pecuniary interest. Again, it may be a loving and caring daughter, sister, brother or son who does it, but that gets confused. I am very concerned. The minister said earlier that if there were an appeal to the Supreme Court, these principles would form part of the basis of that appeal, and that would guide the Supreme Court in considering the matter. I am concerned that using the term “abuse” is far too narrow. I wonder, minister, why it would not be proper to include abuse, coercion and undue influence in that clause, to make it very clear.

I resonate that I am not a lawyer, which is patently obvious, but it strikes me that this legislation could set a very high bar. In the great majority of cases, it will be not be overt bullying; rather, the influence will be subtle and difficult to detect and would be called undue influence, which is a body of law, obviously, and coercion. Why will the government not extend it to that to make it very clear that this is something that should be considered?

**Mr R.H. COOK:** The point is well made. Obviously, we have used the term “abuse” in the widest possible sense. I draw the member for Cottesloe's attention to clauses 99 and 100, which go to the very heart of what he is talking about and provide the offences under the act. For example, clause 99(2) states that a person commits a crime if the person, by dishonesty, undue influence or coercion—I think the member used those words—induces another person to make a request for access to voluntary assisted dying or to access voluntary assisted dying. Further, under clause 100 —

A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person to self-administer a prescribed substance.

The reference to abuse anticipates the full range of ways that a person might influence a person to make a decision, which would be illegal under the legislation.

**Dr M.D. NAHAN:** The member for Cottesloe will come back later. I refer to principle 4(1)(d).

**Mr R.H. Cook:** Is it 1(d) or (e)?

**Dr M.D. NAHAN:** Clause 4(1)(d), which relates to palliative care.

**Mr R.H. Cook:** It is (d) for dog.

**Dr M.D. NAHAN:** Yes, it is a dog day at night.

The minister said that \$206 million has been allocated over the forward estimates, which is an increase on what has been spent in the past. Can the minister provide by way of supplementary information what was spent on

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palliative care in the previous four years so that we can see a transition, a time series, of government expenditure on palliative care? Could the minister also give us an indication, if he can, of the number of people in each one of those years who accessed palliative care so that we can put it on a per patient basis?

**Mr R.H. COOK:** Yes, member, I undertake to do that.

**Dr M.D. NAHAN:** It is late at night and maybe I am hallucinating. I refer to clause 41(a), which states that every human life has equal value. I accept that as a central value set of almost all legislation we deal with, but what we are dealing with is legislation to facilitate a patient's decision that their life does not have the same value as those whose lives to which this legislation will not apply. How does that provision work in the legislation? I am a bit confused about this.

**Mr R.H. COOK:** The member is right—every life does have equal value. I do not accept the member's argument about a person who exercises decisions about their life when their pain is intolerable. Their life, like all lives, will inevitably come to an end, but in their case that end is imminent. I do not think that necessarily devalues the person's life. It underpins the values of this legislation—we do value life and we value a person's capacity to make decisions about their life.

**Dr M.D. NAHAN:** I will leave that; it is too heavy for me right now, but I understand the principle of it. Some of us have learned experiences and have heard stories. I go back to clause 4(1)(i) and the issue of abuse. We hear stories of what is not even undue influence, in which a patient believes that they are a burden on society. The loved one might not even give that impression, but when someone is on a pathway to death, particularly if they are older and life has largely passed them by, there is a natural inclination, we have heard, for a patient to be slightly depressed. We often hear that people do not want to be a burden on their family or children. That is not abuse if the family is not giving that impression. If they are giving the impression, even subtly, that is not abuse, and I do not think it would be picked up as abuse, but this issue keeps coming up when dealing with elder abuse and perceptions of elderly people who, I suggest, will be a large part of the demographic that will use voluntary assisted dying. How will that be dealt with?

**Mr R.H. COOK:** The member is right. That is potentially not abuse. It is coercion. I understand the point the member is making.

**Dr M.D. Nahan:** It might be very subtle.

**Mr R.H. COOK:** Absolutely! It is incredibly important that the training the medical practitioner undertakes provides them with the capacity to understand that coercion and the subtlety of it or someone inadvertently encouraging the patient to access voluntary assisted dying. When there is even an inkling of that, the medical practitioner will be bound by the legislation to seek further advice and not simply say that it might or might not be. If there is a shadow of a doubt, they will have to refer it to someone else who can provide further advice about that. Members should not forget that two medical practitioners will have to come to the same conclusion independently of each other. The mandatory training that they will engage in will equip them with a number of extra skills, in addition to the skills that they already have as medical practitioners, which will allow them to gain further insight into that process. The member is right. That has been looked at extensively in all the jurisdictions. My attention has been drawn to the Oregon data, which looked at the reasons people wish to access voluntary assisted dying. Basically, it indicates that being a burden was not the only or even main motivating factor for choosing assistance to die. In fact, it was well down the list. The chief reasons for accessing voluntary assisted dying were loss of autonomy, dignity and enjoyment in life. The member is absolutely right to highlight the importance that coercion may play in that process. That is why we have set out explicit offences under the legislation when someone coerces someone to access voluntary assisted dying.

**Dr M.D. NAHAN:** To confirm something for future adjudication perhaps, is the minister of the view that the word abuse includes even subtle coercion? Again, this is the feedback that I receive from my constituents when I talk to them about this.

**Mr R.H. COOK:** Yes. That is absolutely my understanding.

**The SPEAKER:** Leader of the Opposition.

**Dr D.J. Honey:** I'm outranked again!

**Mrs L.M. HARVEY:** You have to speak up!

**The SPEAKER:** It is called the pecking order!

**Mrs L.M. HARVEY:** Clause 4(1)(h) states —

a person is entitled to genuine choices about the person's care ...

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]

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Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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Why is that described as genuine choice?

**Mr R.H. COOK:** Again, a range of members in this place made comments during the previous debate that if people are to access voluntary assisted dying, they want them to do so for the right reasons, not for the reasons the member for Riverton just pointed out. They want that decision to be genuine and for them to be able to make that choice based upon their needs, not upon a range of other factors that might impact on it.

**Dr D.J. HONEY:** Just to close the loop on that, clause 99 refers to prosecutions, and I appreciate that the minister has outlined that other words like “undue influence” and “coercion” are used there. Is it possible for us to get a considered opinion from the minister’s legal advisers that abuse in this clause can, indeed, include coercion and undue influence? I appreciate that it may not be possible to give that clear explanation now, but if a court is going to use this as a basis for challenging a decision, I think it is important that it is very clear that the term “abuse” includes coercion and undue influence.

**Mr R.H. COOK:** Again, we come back to the issue of what the principles are about. They are basically about the intent of the legislation and they inform the way in which it should be interpreted in the future. To put the member’s mind absolutely at ease, that is why I highlighted clauses 99 and 100, which actually go to the single point of coercion. “Abuse” is a broad term that captures concepts of coercion, influence and so forth. “Coercion” is explicitly stated in the bill.

**Mr D.T. REDMAN:** Good morning, minister. Clause 4(1)(h) refers to a person being entitled to genuine choices about their care, treatment and end of life, irrespective of where in Western Australia they live, and having regard to their culture and language. When someone sees a doctor for a normal consult, depending on their circumstances they may perhaps be means tested and they may access some concessions and support services from the federal government. Can the minister confirm that the same concessions and subsidies, such as the patient assisted travel scheme, will apply to someone who is seeking voluntary assisted dying services—in other words, the whole package of concessions and supports that would normally go to someone, compared with when they are seeking voluntary assisted dying services?

**Mr R.H. COOK:** The member is right to refer to people who access a range of services in a range of contexts, but certainly they will be eligible for all the other services that we would expect them to access through the Department of Health.

**Mr D.T. REDMAN:** Further to that, there could be some elements of the process of voluntary assisted dying that perhaps fall slightly outside what might normally be called the health arena. For example, would PATS concessions apply to those elements of the pathway of voluntary assisted dying?

**Mr R.H. COOK:** It would be the same as if they were accessing the range of specialist services. The example the member gave was PATS; yes, they would be eligible for PATS. If they are accessing services through their GP, obviously a range of federal concessions and rebates could be brought to bear in that context. In the normal manner that we would expect someone to interact with the health system, they will have access to all those forms of subsidy, assistance and public funding.

**Ms M.M. QUIRK:** Again, I return to clause 4(1)(i) and the discussion that some members have been having about the term “abuse”. The minister has rightly pointed to the offences under clauses 99 and 100. Clause 99(2) commences —

A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person —

I am not quite sure why that language is not used in clause 4(1)(i) to make it consistent. It occurs to me, for example, that if a patient assistant or a nurse were to go up to a person who wanted more pain relief and said, “You silly old bugger”, that, in the natural meaning of the word “abuse”, would fall within that category.

The other issue about section 99 is that the horse has bolted by then. It would be better if that person could not be subject to coercion or duress before they die. It is such a short time frame that the investigation and a finding about coercion and abuse will be after the event. I am really concerned that that is very loose language and there should be some consideration given to it. I do not know what is in the Victorian legislation—I can probably look it up while the member for Cottesloe gets to his feet—but to me that is not consistent with the criminal provisions that the minister alluded to.

**Mr R.H. COOK:** We can deal with the details of clauses 99 and 100 when we get to them. What we are doing through the principles, essentially, is casting the net wide and then narrowing it down when we specifically talk about the offences. To use the concept to say “someone who may be subject to abuse” is to cast it in the very

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widest terms. "Abuse" in this context has been borrowed straight out of the Victorian legislation and is about the general context and influence on a person when they make their decision.

**Mrs A.K. HAYDEN:** If clause 4(1)(c) is not the right place to ask this question, I would really appreciate the minister indicating under what clause I can discuss this. I note the member for Cottesloe asked about the cost over the next four years and the minister provided the answer. Clause 4(1)(c) states —

a person has the right to be supported in making informed decisions about the person's medical treatment ...

Obviously, this is all about the treatment that they are able to access and that is available to them through this legislation. I know the minister addressed some of it in his reply to the second reading, but I did not hear all of it. The minister has said that the state government is going to bear the cost. Will it bear the cost of the whole service? Will there be a cost to the patient at all? Will a Medicare number be associated with any of the costs, whether it be a doctor's appointment, assistance, reports and so forth? I would really like to understand the cost of this legislation. What will it cost to access voluntary assisted dying? What part will the government pay and what part will the patient pay?

**Mr R.H. COOK:** There is no specific Medicare benefits schedule item in relation to this. At this stage, we are still getting a line of sight of any out-of-pocket expenses in the Victorian legislation. It would be the same way that a person would access any other health service. As I said to the member for Warren-Blackwood, there would be one specific relationship with the GP, for instance, who is involved in the process. It might be undertaken in an aged-care setting and, clearly, a person would have their own arrangements with the aged-care provider. They might be in a tertiary hospital. Clearly, that is within the health jurisdiction, so there would not be any costs associated with that. There will be no costs associated with specialist services that are accessed via the Department of Health. I cannot vouch for every aspect of a person's care, because it will be a fairly complex matrix of services that are accessed. In terms of the basic services they would receive from the WA government through the Department of Health, those services will be publicly provided like any other health service.

**Mrs A.K. HAYDEN:** I want to understand. When I access any other public health service, I present my Medicare card and I get the rebate. Some GPs charge for the gap between the cost and the Medicare rebate. If this will not have an MBS item number, how will the minister guarantee that there will be no cost and the state government will cover the bill? Will the person need to go to a state hospital? I am not trying to be awkward or extend the debate; I am trying to understand. If I go to a doctor, I use my Medicare card, and I am either bulk-billed or pay the gap. If I go to a private doctor, I pay that doctor his or her fee. There is a whole process that we need to understand. If there is a gap, who will pay for it? How will people be able to pay for it if they cannot afford to get themselves to palliative care? This is my concern. If people cannot afford that, how will they be able to afford this? I would like an explanation. Has money been allocated in the budget for this, or will it be new money?

**Mr R.H. COOK:** It will depend on the context in which the person accesses the service. For instance, if the person was an outpatient at a public hospital, they would not even have to present their Medicare card. They would simply receive the service, as they would if they were receiving a service in any other hospital as an outpatient. If the person engaged a general practitioner, they would have a relationship with that general practitioner. I guess the nature of the GP relationship may be such that, as the member said, there are no out-of-pocket expenses. However, if people have a particular GP in mind, there might be expenses. The medications would be provided by the state in that particular context. Again, it goes to the question that the member for Warren-Blackwood asked. If a person is receiving care under the Department of Health, it would be free of charge.

In answer to the member for Cottesloe, the cost to the state in Victoria was \$6.35 million. Obviously there will be a need, following the implementation period, for the department to provision for the costs associated with administering this act.

**Mrs A.K. HAYDEN:** I thank the minister for that explanation. The person has gone to their GP and their costs have been covered, and they are then able to access the substance or the poison or the drug or whatever we will call it. Does the minister know how much the actual substance that people will take will cost?

**Mr R.H. COOK:** No, member. That will obviously be worked out in the implementation phase. There will need to be a clinical oversight panel that will first decide what those substances will be.

**Ms L. METTAM:** I refer to clause 4(1)(c) of the principles, with reference to palliative care. I assume this is an acknowledgment that palliative care is necessarily interlinked with the introduction of the Voluntary Assisted Dying Bill. To that end, the issues surrounding palliative care in regional Western Australia are obviously significant. I acknowledge that the government has committed \$30 million to palliative care in regional Western Australia. What sort of time frame can we expect for a strategy for the delivery of those additional funds to the regions?

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**Mr R.H. COOK:** That was a wide interpretation of the principles, but I am happy to go to it because it is good to have the information out there. I committed to consult with the palliative care industry on the best way that we can spend the resources that we have. Part of that commitment was to hold a summit, which was held the weekend before last. Representatives from the palliative care industry looked into a range of those issues. I have asked the department to take away those learnings and ensure that the outcomes of that summit inform us.

**Ms L. METTAM:** What sort of time frame can we expect before we understand where those funds will be allocated in the regions?

**Mr R.H. COOK:** It will not be very long, member. I have asked the department to get a wriggle on with that. The findings from the summit are now public, and I think they are available on the Department of Health's website. I have asked the department to come back to me as quickly as possible so that we can put some flesh to that. I understand that, particularly in the context of this debate, people want to get some understanding of that stuff.

**Mr P.A. KATSAMBANIS:** Still discussing the principles, I note that paragraph (j) states —

all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

I think that is a statement that everyone in this place can agree with in all respects, not just in respect of this legislation. We discussed during the second reading debate specifically the issue of those health practitioners who have ethical, moral, conscientious or other concerns about engaging in this process of euthanasia, assisted dying or however we phrase it. I am concerned that the provisions in the bill fail to meet the principles articulated in the bill for health practitioners. As I pointed out in my second reading contribution, as did other members, there are plenty of cases in our medical system in which doctors can simply say, "I don't engage in that practice." They can do that for things such as medicinal cannabis, abortion and the like. Some clinics pride themselves on not supporting a patient's choice to have iron infusions and would prefer them to take supplements instead. That is an example that I am aware of. Doctors and other medical practitioners are not forced to undertake steps beyond simply saying, "No; it's a competitive market. You can see somebody else if you want to continue with that practice." To comply with this legislation, which I think is unique in Western Australia, if a doctor has a conscientious objection, they will need to follow a series of legislative steps. They cannot simply say, "No, I'm not interested in that; I'm not going to participate. You might want to seek advice from someone else." They will have to provide the patient with a certain form. It is not a prescribed form; it is a form authorised by the CEO, and I am sure we will deal with that when we get to that clause. We do not know what that form will look like, but we can imagine that it will contain information about how people can access the assisted dying regime under this legislation. They will also have to fill out a separate form, with all sorts of details, including the reason why they refused the request, and send it to the board. There could be multiple reasons or it could be because they did not believe the person had capacity, they were concerned about coercion or they were simply conscientious objectors.

Why would we frame a series of principles with these noble statements, including the noble statement that all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics, and then a few clauses later—we will discuss it in detail later—in clause 19, trash that very principle that is enunciated in the bill? Is this a good way to show good faith with the principles that the minister and the government are enunciating in this legislation?

**Mr R.H. COOK:** As the member said, we will come to that clause in due course, so I will not discuss the details of that right now. Essentially, we are balancing the need for medical practitioners to be in a position to participate on a voluntary basis against the duty of care of the patient involved. The legislation not only acknowledges that a health practitioner should be respected in those dimensions that the member has mentioned, but also is balanced against the need of the patient to receive the information that they need. So, it is a balancing act between the duty of care and the obligations that we have for that patient to be supported in the process, with the voluntary nature of the participating health practitioners.

**Mr P.A. KATSAMBANIS:** So why does clause 4(1)(j) not say "all persons, including health practitioners, have some right to be shown respect for their culture, religion, beliefs, values and personal characteristics"? Why does it not say that they have that right subject to a balancing act between various other rights? Why does it make this glib statement that health practitioners have this right when, clearly, the legislation that makes this statement is taking away a significant part of that right?

**Mr R.H. COOK:** The member would be familiar with the context of the principles that underpin the legislation. They are there to be read as a whole. Essentially, the principles come together to form the values that underpin the

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legislation. The member knows that we are always balancing rights and obligations against each other to make sure that we strike a balance that the community regards as appropriate.

**Mr P.A. KATSAMBANIS:** I know it is late at night—early in the morning actually—and I promise the chamber that I will not sing, but I am reminded of some lyrics by one of my favourite bands, Metallica, in their song *Eye of the Beholder*. I will not sing the lyrics, but in *Eye of the Beholder* there is a great line that says, “You can do it your own way if it’s done just how I say.” That is how I feel when I hear that from the minister tonight on this principle, because, yes, it is enunciated there, but it is enunciated as a clear right. That is what it says. We challenged the minister and asked: Is it really the case? Does this legislation enshrine this right? The minister said, “No. It’s a combination; it’s got to be read together and it’s got to be balanced.” But it does not say that in the bill. If we take out this clause, which is a statement of principle—it is meant to be the guiding and shining charter, if you like, for what we are doing here—it does not say that. It does not say that everything has to be balanced. It does not say we have to play one off against the other. It says, “You can do something”, and further down it says, “You can only do it in the way that we say you can do it. You don’t get any other choice.” Again, this is another issue that gives rise to concern in not only people like me—I have stressed that from the outset—but those people who would probably feel comfortable supporting a bill that did some of the things that the bill purports to do and was based on the principles that this bill claims to be based upon, but are genuinely concerned that it will infringe upon a right to conscientious objection and a right that is actually spelt out in the very legislation that infringes upon that right. I think that this is a terrible precedent to set—to articulate a right and in the same bill fetter it or take it away. I guess we will reach an impasse on this, but it really strikes me as though these principles were lifted out of the Victorian legislation. It is almost a direct lift, not quite word for word, and then nobody compared the principles with the operating provisions of the bill. It is at best sloppy, but at worst, and I fear that this is the case, it is really only paying lip-service to a principle when, in actual fact, it is a right that will be taken away, not affirmed.

**Mr R.H. COOK:** As I observed before, these principles underpin the operations of the bill; they do not of themselves prescribe the clauses of the bill. Every doctor and health practitioner regardless of their beliefs and so forth still have professional ethical obligations for the way they carry out their work. Obviously, they do it in the context of their faith and cultural setting in a number of ways, but that still does not detract from the fact that they have a range of obligations to patients regardless of those features. As I explained before, these principles together underpin the values that inform the legislation, and, ultimately, by which it would be interpreted and inform other decisions. But it does not undermine the obligations that a medical or health practitioner would have in any respect to a duty of care to patients.

**Mr P.A. KATSAMBANIS:** I am no expert in body language or lip-reading or anything like that, but I thought that when I suggested that these principles were based very closely on the Victorian principles, the minister mouthed, “No.” Did I miss that?

**Mr R.H. Cook:** I think the member was trying to suggest that we lifted from the Victorian legislation. That is not the case.

**Mr P.A. KATSAMBANIS:** Can the minister articulate to me in which meaningful way the principles contained in clause 4(1) differ from the principles that are contained, I think, in section 3—I am happy to be corrected—of the Victorian Voluntary Assisted Dying Act 2017?

**Ms M.M. Quirk:** It is section 5, member.

**Mr P.A. KATSAMBANIS:** Section 5, is it? Okay.

**Mr R.H. COOK:** As I have explained before, the ministerial expert panel spent a lot of time considering the principles that underpin the legislation. We are informed mostly by its considerations. I am advised that both pieces of legislation contain guiding principles similar to each other, with the Western Australian bill reflecting the drafting language used in WA and the unique WA context—for example, making reference in the principles to regional accessibility and genuine choice, irrespective of where a person lives in WA, and having regard to the person’s culture and language. I am quite happy to provide the member with a copy of the Victorian legislation principles in due course if that is helpful.

**Mr P.A. Katsambanis:** I have it right here.

**Mr R.H. COOK:** Fair enough. As I said, the ministerial expert panel spent a lot of time looking at the Victorian principles and examining legislation in other jurisdictions. It in turn informed what it thought was appropriate for Western Australia.

**Dr M.D. NAHAN:** Further on this issue, it has just come to mind—this might not be the right spot—that later in the legislation we apply clause 4(1)(j) to health practitioners. What about the institutions in which people are resident,

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whether it is a hospital, a hospice, or an aged-care home that has an institutional ownership that is against VAD? Let us say it is a Catholic hospice. I have not seen that raised in the debate so far. Could the minister discuss that?

**Mr R.H. COOK:** I raised it in my concluding remarks in the second reading stage, but I am informed that the faith-based hospitals are able to object to participating in the voluntary assisted dying processes for any reason, including, but not limited to, conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of an individual or organisations who do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

**Dr D.J. HONEY:** I want to talk about this clause, but I note it is now after 12.30 am and most people have been up for more than 18 hours. We talked about treating people with respect and that this is the most important bill that many people have probably ever seen. I do not think it is appropriate for us to be here now. We are all tired —

**The SPEAKER:** Member, can you talk on the clause.

**Dr D.J. HONEY:** I can, thank you, Mr Speaker, but I think this is an important point. I do not think it is appropriate that we are doing this now. We are not treating it with the respect it deserves. Hopefully, this can be the last point, minister. Clause 4(1)(f) states, in part —

a person should be encouraged to openly discuss death and dying ...

I refer also to paragraph (g). I wonder whether those provisions will compel a doctor to be involved in those discussions. The minister referred to my response to the second reading speech a number of times, so obviously he has read that and certainly listened to it. Therefore, he would know that one of my great concerns is that a doctor—I believe that many doctors are in this position—who is genuinely totally opposed to this and wishes to have no involvement whatsoever could be compelled by these provisions to be involved in those discussions whether they care to be or not.

**Mr R.H. COOK:** As the member would be aware, and as I was just discussing with the member for Hillarys, there are obligations on health practitioners and medical practitioners under this legislation. That is not one of them.

**Dr D.J. HONEY:** Is the minister saying that under this legislation, doctors will be compelled to have those discussions with patients? It is a late hour. Is the minister saying that they will or will not be?

**Mr R.H. COOK:** No, they will not be compelled.

**Dr D.J. HONEY:** Further to that, I see that clause 4(1)(j) states —

all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

I will not go through the clauses now; we will do it at the right time when we come to it in the bill, but it appears that a doctor can be compelled, for example, to give a person who is requesting access to voluntary assisted dying under this legislation information so that they can access it even if they do not personally agree with that at all. I wonder why we do not have any specific statement about the rights of a doctor. I think it would be appropriate to legislate that a doctor should not be compelled to participate in VAD because, as I have said before, many doctors with whom I have spoken are fundamentally opposed to any involvement in this process.

**Mr R.H. COOK:** I appreciate that the member for Cottesloe, of all members, would have a number of doctors in his constituency who have taken an acute interest in this debate. I answer that by saying that the principles guide the legislation and underpin the values that inform it.

The specific area the member is talking about is covered in clause 9, which we will come to in due course. But, again, a doctor, medical practitioner or health practitioner will be governed by a whole range of laws, jurisdictions and regulations consistent with their training and their registration as a health or medical practitioner, which places obligations on them and affords them rights and privileges. This legislation is no different. As I explained to the member Hillarys, this is about making sure that we balance the needs of the doctors' perspectives to be respected against the need to provide a duty of care within an ethical framework for the patient.

**Dr D.J. HONEY:** I am not quite sure I heard the answer in there, but just to be clear, does clause 4(1)(j) include the principle that a doctor should not be compelled to participate in voluntary assisted dying?

**Mr R.H. COOK:** That is correct. I think the member's initial question was: are they compelled to be involved in conversations? No, they are not. In the event that someone makes a request under voluntary assisted dying legislation and that person cannot for a whole range of reasons participate further, their obligations are about what they must do in terms of the provision of information.

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**Ms M.M. QUIRK:** We had a discussion earlier about the similarity between the principles in section 5 of the Victorian act and clause 4 of this bill. As the minister correctly pointed out, clause 4(1)(h) is somewhat different because we include the phrase —

... irrespective of where the person lives in Western Australia and having regard to the person's culture and language;

How does the minister see that playing out in practice, given that the WA police service—luckily the minister is not in the room!—seems to have enormous problems training its officers in cultural competence in the Pilbara and the Kimberley? I wonder what the minister anticipates and how that will be implemented in practice.

**Mr R.H. COOK:** In my response to everyone's second reading contributions tonight, I talked about the system navigators that have been employed in Victoria. We could certainly see those navigators playing a role to assist someone to interact with the process itself, and we could see them playing a cultural or language role as well. Those issues will ultimately be teased out in the implementation phase. The member is quite correct. This is important legislation, so it is important that, firstly, people have access to it regardless of their culture, language, background or where they live, and, secondly, when they seek access to it, they are completely informed of their rights and obligations. From that point of view, we will need to proceed carefully. There would obviously be a big obligation with regard to the written information and how it comes across, and that is why the director general has an explicit role in this legislation through oversight and the prescription of a lot of that information.

**Mr Z.R.F. KIRKUP:** I am keen to clarify one element that the member Hillarys raised about clause 4(2), which states that the tribunal must have regard to the principles as well. I realise this is largely a replication of the Victorian legislation and replicates, I think, the Victorian Civil and Administrative Tribunal clause. I am keen to understand, if we can, why the legislation specifically outlines that the tribunal needs to give regard to these principles. Of course, all practitioners and every other participant must have regard to this clause, as per my first question. I am keen to understand why we spell that out for the tribunal.

**Mr R.H. COOK:** Member, I am informed that the reason that is explicitly stated is that the tribunal plays a pretty crucial role in how this bill would work. From that point of view, it is important that the bill explicitly states how the tribunal should inform itself.

**Ms M.M. QUIRK:** I want to get some clarification from the minister about clause 4(1)(j), which states —

all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

Could the minister outline what would be encompassed by the term “personal characteristics”?

**Mr R.H. COOK:** It could be a range of things. If we think about it, we could anticipate that a health practitioner may have a disability or issues to do with age that might impede them from participating. This is about making sure that we really underpin the voluntary nature of this legislation.

**Ms M.M. QUIRK:** I understand the overall reason for having these umbrella principles, but if the minister were to draw a Venn diagram, how would they differ from, say, a patient's rights under the Australian Charter of Healthcare Rights? Would there be any overlapping or are they different in some way? I am curious because that sort of thing would be in existence anyway, I would think.

**Mr R.H. COOK:** I am not personally familiar with specific charters, but it is obviously using the same sort of language—person-centred care, valuing the patient, valuing the therapeutic relationships—so there would be some intersection between the two documents.

**Mr P.A. KATSAMBANIS:** In clause 4(1)(c), the first mention is made in this legislation of the term “palliative care”. Many of us have discussed in our contributions how palliative care can be misunderstood in many ways. By what reference is palliative care defined in this legislation? I note that there is no definition of palliative care in the definitions section. What definition of palliative care is being used in drafting these principles?

**Mr R.H. COOK:** I am advised that the term “palliative care” is not defined in the bill because the contemporary common meaning will apply. In this way, registered health practitioners are not excluded or limited from applying, consistent with their duties, wider care and palliative care treatments aimed at improving the quality of life for the individual, including assistance to the patient's family and/or carer. There are well-established palliative care networks in Western Australia that assist with this, and the Department of Health works closely with them. For instance, I am advised that the definition referred to in the Guardianship and Administration Act is quite outdated. This view was reflected strongly by the Ministerial Expert Panel on Voluntary Assisted Dying via the Department of Health's consultations, including the consultations with the palliative care networks. I think the member is right.

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Palliative care is an emerging field of care in the health jurisdiction and nowadays it has a much wider meaning than was previously considered.

**Mr P.A. KATSAMBANIS:** Is the term “palliative care” defined anywhere in Western Australian health legislation?

**Mr R.H. COOK:** It is defined under the Guardianship and Administration Act 1990.

**Mr P.A. KATSAMBANIS:** I do not have a copy of the Guardianship and Administration Act in front of me, but I believe—the minister might be able to correct me if I am wrong—that it is defined by using a reference to other matters rather than a direct definition.

**Mr R.H. Cook:** I will seek some advice.

**Mr P.A. KATSAMBANIS:** Can the minister clarify that? Just read out what it says, maybe.

**Ms M.M. QUIRK:** If I could assist, under the Guardianship and Administration Act 1990 —

*palliative care* means a medical, surgical or nursing procedure directed at relieving a person’s pain, discomfort or distress, but does not include a life sustaining measure ...

I have foreshadowed that I will move an amendment to insert a definition of “palliative care”. I have used that definition because it is elsewhere in legislation. I cannot see what in that definition makes it outmoded.

**Mr R.H. COOK:** Member, we were simply informed during consultations with the palliative care networks and other experts in the field that it is considered to be a rather restricted and outdated perspective of what palliative care means. Palliative care in the broader sense is now a much longer, more holistic treatment process and, from that perspective, even as the member quoted the definition from the act in that instance, I found that it would jar with some of the hospice work and broader work done in the palliative care field.

**Mr P.A. KATSAMBANIS:** I note that as we discuss clause 4, the principles contained in it are very closely aligned with the principles in the Victorian legislation, which passed about two years ago. The Western Australian Ministerial Expert Panel on Voluntary Assisted Dying was strongly informed by those principles. I also note that the principles in the Victorian legislation use the term “palliative care” but its drafters chose to define the term “palliative care” in the legislation. They define it by referring to the Victorian Medical Treatment Planning and Decisions Act 2016, which states —

*palliative care* includes the following —

It is an inclusive definition —

- (a) the provision of reasonable medical treatment for the relief of pain, suffering and discomfort;
- (b) the reasonable provision of food and water;

The drafters of the Victorian legislation chose to provide a definition of “palliative care”. They use the definition that was included in the broader legislative framework, the Medical Treatment Planning and Decisions Act 2016. Have we identified a gap in the Western Australian legislative framework, whereby we need to include some form of inclusive, rather than exclusive, definition of “palliative care” so that when people start to look at these matters, not just simply in a legislative sense but also in a government funding sense and in the provision of care across the community, at least everyone would start from the same page rather than reinterpreting things from a blank page.

**Mr R.H. COOK:** I cannot comment on how the legislation in Victoria evolves from that point onwards in terms of references made to the term “palliative care”. We have used it in the context of the principles as opposed to more prescriptive elements of the bill. The principles use “palliative care” in the broadest terms and in the contemporary common usage of the term. It is not, in that context, necessary for us to nail down the definition because it does not create an instrument anywhere else in the legislation.

**Mr P.A. KATSAMBANIS:** The member refers to contemporary common usage. What are the limits of the contemporary common usage? Is there a series of guidelines or some sort of framework provided by the Department of Health to articulate what palliative care is or what may be included in palliative care? When the minister refers to a contemporary common usage, where should people go to find out what the contemporary common usage is?

**Mr R.H. COOK:** I refer the member to Palliative Care Australia and other reputable organisations that are involved in the industry. I also commend the “WA End-of-Life and Palliative Care Strategy 2018–2028”, which provides a very broad and detailed account of what end-of-life care looks like, and palliative care in that context.

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**Mr P.A. KATSAMBANIS:** I thank the minister for the reference. I will look at it when I get an opportunity, because it is important. From our discussion, it appears to me—the minister can confirm this if he can—that within the Department of Health there is no agreed common meaning of palliative care. If that is the case, is it not a bit glib to say that “palliative care” means its common contemporary meaning? There does not seem to be a settled phrase. At the very least, Victoria has a settled inclusive definition in its legislation, so that is a good starting point. It seems to me that in Western Australia, despite best intentions and guidelines, and the work done by Palliative Care Australia, which is not a government entity and certainly not a Western Australian government entity, we are not all working from the same common starting point on this critically important issue.

**Mr R.H. COOK:** Again, I refer the member to the department’s strategy document for definitions of palliative care. In particular, I refer the member to the fact that this clause is about broad principles that inform the rest of the legislation rather than something that might be considered an application or litigation of an issue. These are the broad principles that together inform the values that underpin the legislation. From that point of view, I do not think it is necessary to define “palliative care”. I take the member’s point and appreciate that he wants to nail down this aspect, but I do not think it is necessary for our bill. Of course, I cannot speak on behalf of the Victorians. They have taken the direction they have. Our drafters have taken a different approach.

**Mr P.A. KATSAMBANIS:** The minister can take this as a comment. I heard from the member for Girrawheen that she intends to move an amendment to attempt to rectify what I consider to be a failing in the legislation, and I am heartened by that. I look forward to the debate continuing so that we can at least consider that as an option. As I keep saying, I do not want an exclusive definition. I recognise that it is an evolving field—almost all medicine is an evolving field—but I think an inclusive definition would at least get us to a common starting point that we can move from.

**Ms M.M. QUIRK:** Just briefly, in this context, this will come up in the next clause, “Terms used”, and as we have already heard, there is no definition. I very much commend the Department of Health for the “WA End-of-life and Palliative Care Strategy 2018–2028”. Under the previous government, the palliative care strategy actually lapsed. I had to dig through it, and I finally found that at page 18, it states —

**Palliative care**

An approach that improves the quality of life of people and their family/carer facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial and spiritual.

The minister might want to think about that overnight. I accept that perhaps the definition in the Guardianship and Administration Act is a bit narrow, but I think there is some value in having a definition in the legislation.

**Mr R.H. COOK:** I thank the member and appreciate her counsel.

**Mr S.K. L'ESTRANGE:** I have been listening to some of the concerns around definitions of “palliative care”. I bring us back to clause 4(1), which states —

A person exercising a power or performing a function under this Act must have regard to the following principles —

The word “must” implies that if they do not, they cannot exercise that power. The word “must” is critically important to what I am about to say. Clause 4(1)(c) states —

a person has the right to be supported in making informed decisions about the person’s medical treatment, and should be given, in a manner the person understands, information about medical treatment options including comfort and palliative care and treatment;

“Must” have regard to that. Let us say, for example, that a doctor acting under this legislation knows full well that the patient they are dealing with in a regional or remote town does not have access to palliative care that would give that person the right to be supported. Under this legislation, that doctor will not be allowed to perform their duty or function. That is what I interpret that to mean. How, then, is the minister going to ensure that palliative care is available to every remote and regional community so that, under the legislation, the person exercising the power will be able to meet the requirement that they “must” have regard to what is written in clause 4(1)(c)?

**Mr R.H. COOK:** As I have said to other members, these are the principles that underpin the legislation, so “must have regard for” means “must consider these principles” in the context of exercising people’s powers, obligations and functions under the legislation. From that perspective, obviously people would give regard to the range of medical treatments that are available to someone.

**Extract from Hansard**

[ASSEMBLY — Tuesday, 3 September 2019]

p6276b-6341a

Ms Mia Davies; Mr Bill Marmion; Mr Tony Krsticevic; Mr Peter Katsambanis; Mr Vincent Catania; Mr Kyran O'Donnell; Mrs Alyssa Hayden; Mr Shane Love; Mr Paul Papalia; Mrs Michelle Roberts; Mr David Michael; Mr Roger Cook; Dr Mike Nahan; Mr John McGrath; Mr Sean L'Estrange; Ms Margaret Quirk; Mr Zak Kirkup; Mrs Liza Harvey; Mr Terry Healy; Dr David Honey; Mr Terry Redman; Ms Libby Mettam

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**Mr S.K. L'ESTRANGE:** There is a reason why “Principles” appears right at the front of this bill; it is because these principles underpin the very nature of how every aspect of the bill is to be executed in the community once the bill is passed and made law. So, no, minister; principles are not just things we look at and have a think about, because when we fail a principle, it can have a consequential damaging effect on how we go about executing what this bill proposes to do. I ask: how can the minister ensure that a doctor acting under this legislation must have regard to clause 4(1)(c) for that person to be supported with proper palliative care? How is the minister going to prevent that doctor from acting if they cannot achieve what is set out under clause 4(1)(c)?

**Mr R.H. COOK:** I think we are starting to get into the realms of repetition. As I have explained, these are the principles that inform the bill. Someone exercising their power or performing a function under this bill would have to consider these principles. They are not binding, they are not exclusive and they are not inclusive; they are principles they have to have regard to. With respect, member, we have ventilated the issue of the principles extensively in terms of what is their function. I understand the member's passion about his, but he is really just bringing us back to the original point: what is the role of the principles? We have really ventilated that issue quite well.

**Mr S.K. L'ESTRANGE:** I thank the minister for his counsel. I stand here as the member for Churchlands, irrespective of what any other member representing their seat has said so far on this debate, and whilst I have heard the minister's counsel, it is irrelevant. What is relevant is that the minister just said these principles do not matter and that a person does not need to act on those principles.

**Mr M. Hughes** interjected.

**Mr S.K. L'ESTRANGE:** The member for Kalamunda can have his say when he gets to his feet to take the call.

Is the minister saying that, under the bill, a person exercising power does not have to have regard to these principles?

**Mr R.H. COOK:** With respect, member, that is not what I said and I think the member knows that is the case. The principles serve as a guide in interpreting and applying the bill but they do not create legal obligations. They are principles that people should consider or have in mind in relation to this legislation. From that perspective, I think this is the same point that I made to the member for Hillarys, the member for Darling Range and the member for Cottesloe, and I appreciate the points that people have raised. They are very important.

**Clause put and passed.**

Debate adjourned, on motion by **Mr R.H. Cook (Minister for Health)**.

*House adjourned at 1.07 am (Wednesday)*

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