

**PALLIATIVE CARE**

*Motion*

**HON NICK GOIRAN (South Metropolitan)** [11:36 am] — without notice: I move —

That this Council —

- (a) congratulates the state government for its commitment to expand palliative care services throughout Western Australia, especially through the additional funding of \$14 million provided through the Palliative Care Services Fund from 2009–2012 for projects including establishing —
  - (i) rural palliative care across seven Western Australian country health service regions;
  - (ii) two mobile specialist palliative care consultancy teams in the metropolitan area; and
  - (iii) a statewide paediatrics palliative care program under the auspices of Princess Margaret Hospital;
- (b) noting that dignity therapy is a psychological tool which helps health care providers to affirm the personhood and dignity of the patient and costs about \$500 per patient, calls on the state government to consider ways of ensuring that the funding of palliative care in Western Australia includes funding for dignity therapy; and
- (c) encourages the state government to continue to expand its support for palliative care to ensure that —
  - (i) palliative care is given higher priority in educational programs, including continuing education programs, for doctors, nurses and other health professionals;
  - (ii) palliative care is better integrated as an essential part of all health services throughout Western Australia; and
  - (iii) appropriate palliative care is available for persons with chronic diseases as well as those with cancer and other terminal conditions.

Some of my colleagues thought my speech would end once I had concluded moving the motion! However, I would like to make a number of other remarks in support of the motion. I will start by making the remark that in my view, on the whole, Western Australia has a very good palliative care model and service delivery. I congratulate Minister Hames, the Minister for Health, and the Department of Health for their commitment to palliative care. I think, as members and constituents, we are very blessed to live in a state where life is valued and the palliative care we offer is sophisticated and the importance and value of quality palliative care is recognised. However, I note that with the population aging and as baby boomers hit retirement, palliative care will continue to face an increasing demand. It is my keen desire to see that any gaps that exist in the palliative care system are filled so that people are held and borne at the end of their life so that death, dying and bereavement are seen as a natural part of life.

I want to quote an article from *The Lancet* of 30 May 2009 titled “Dying and choosing”. It is to do with the challenge of keeping pace with demand. I quote as follows —

Along with other ... advances in clinical practice, palliative care has come of age, with specialist palliative care teams in major hospitals and in hospices. Sadly, stories of “bad deaths” have not disappeared, largely because the spread of palliative care skills, both geographically and within health care, has not kept pace with its advances in quality.

I turn to the situation of modern-day palliative care. I note that the past two decades have transformed the situation for dying patients. Modern-day palliative care is about more than just relieving pain and other symptoms that cause suffering; it seeks to get to the bottom of what is causing distress—whether it be psychological, physiological or spiritual—to empower patients to receive care how and where they wish and generally to restore quality to their last months, weeks or days.

The calls that have been made around the globe for doctor-prescribed suicide are linked with ideas of unrelieved suffering, intractable pain and the fear of the unknown. The language used by the proponents of those calls is generally emotive and descriptive, but not necessarily an accurate reflection on the reality of the dying experience in today’s Western Australia. It is ironic, I think, that improvements to care for the dying around the world have also been accompanied by increasing calls for legislative change. We have to consider why this is the case. Some would argue that in the West we try to sanitise anything unpleasant and that the natural processes of

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life such as birth, breastfeeding and dying are shut away behind closed doors so that they are no longer recognised as natural but are seen as unnatural and to be feared.

Alternatively, perhaps we are not educated enough on what death and dying are really about. I have to say that I found myself in that category prior to being sworn in as a member of this house. I am therefore thankful for the likes of Dr Margherita Nicoletti and her team at St John of God Health Care Murdoch Community Hospice in my electorate. I have had the opportunity to go and see them at their facility and to talk to the staff and their patients and families. The experience I had there two years ago, I have to say, is one of the highlights of my time here in Parliament because it gave me an authentic glimpse at the journey that is as difficult as it is valuable, and as sad as it is rich. I saw many tributes from families and friends expressing the comfort that they had received. During my visit I saw people, some with ailing bodies and some with battered hearts, coming alongside one another—encouraging, supporting and learning from those whose days were, medically speaking, numbered. In speaking to people, I learnt that they could not speak highly enough of the dignity and quality of care that they were given. The time I spent at Murdoch hospice gave me a greater appreciation for life, for family and for what is really important; it also removed some of my own fear of things unknown.

I remember hearing a story of a pregnant woman in the 1950s who had no idea of what to expect in childbirth. She had not been informed or educated on what to expect during labour and childbirth. What she experienced so shocked and traumatised her that she only ever had one child, as she never wanted to go through the experience again. That was in the 1950s. Fortunately, things have come a long way since then. And of course in the area of childbirth, expectant mothers are offered services, clinics and antenatal classes that give them an idea of what to expect. They can be offered support to help them through what is undeniably a difficult and at times frightening experience. This is a prime example of how education can serve, in my view, to remove fear of the unknown.

Part of my motion this morning discusses this new initiative of dignity therapy. During my career as a legal practitioner I had the opportunity to talk to many people who, after a tragic accident, were suffering emotionally and also mentally in coming to terms with the life-changing situation they faced. I would often, in arguing the case for a victim, cite an overlying mental health issue, which is part of the natural grieving process for the life that once was and the life that now is.

Earlier this year I was informed that Professor Harvey Chochinov would be coming to Western Australia. Professor Chochinov is an internationally recognised leader in palliative care research. He is Professor of Psychiatry, Community Health Sciences and Family Medicine of the Division of Palliative Care of the University of Manitoba; he is director of the Manitoba palliative care research unit, which is called CancerCare Manitoba; he holds the only Canadian research chair in palliative care; he is a recipient of the Queen's Golden Jubilee Medal; and he has received the Order of Manitoba for his work in palliative care. Professor Chochinov is also known as the founder of this new intervention called dignity therapy.

Some members might want to know what dignity therapy is. It is a therapeutic intervention that can help people with a life-altering or terminal illness cope with what has happened and what will happen to them. It is an aspect of palliative care that is of great interest to me, and so I invited Professor Chochinov to come to Parliament to educate me and many of our interested colleagues on dignity therapy. Those members who went to that briefing will recall that Professor Chochinov explained that the will to live is not a dichotomy. That is, it is not a case of having it or not having it; rather, it can fluctuate. In one study that was mentioned the reason given in 57 per cent of cases for a medical decision to end life was loss of dignity. Dignity intimacies are things such as bathing, dressing and incontinence. Dignity is about how people perceive themselves to be seen. Many patients hold onto past images or perceptions of themselves. It is important for them to be seen as these people, rather than to be seen just as sick people.

During illness, personhood can start to vanish. It can start with something as simple as keeping people waiting. They might say that they do not feel important enough for the doctor to attend to them on time, and can end with people feeling that their self has been lost and that they have become their illness. Generativity is the belief that one's life has not had meaning and involves feelings such as, "I am leaving no legacy, no impact; I won't be remembered." These are huge concerns for people with a terminal illness. Dignity therapy is a psychological tool that can help healthcare providers to affirm personhood. It involves a discussion with the patient about their life and what message they may want to pass on to their loved ones. I think the benefits are improved wellbeing of the patient and there is also a multigenerational impact, as it can be of great use to the family of the patient.

There is always the global problem of the limitations of budgets. That is not anything we can escape from. It is just a reality that there is a limited financial pool from which to address any initiative. Often this leads to unconscionable requirements being placed on what elderly people must put up with. In palliative care there is a different bottom line. The cheapest option is if the patient dies. The question is how do we measure the cost of a good death and how do we put a price tag on the mental health of grieving loved ones and family members.

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From what I have understood and researched to date, dignity therapy is far cheaper than any biological medicine involved in palliative care and opens up the conversation surrounding dying. If we were to take this up, we are being offered a way to conserve people's dignity, to protect humans and to develop compassion and mercy in the individual. In my view, if we turn human suffering into something that we will not tolerate it makes us less sensitive to the pain of others. Suffering people deserve compassion but their suffering affirms life.

In conclusion, I congratulate our government on its initiative and compassion in this area, and I encourage that to continue and to be brought to the next level. I would also like to take the time to thank Dr Andrew Dean, medical oncologist and palliative care physician; Professor Paul Skerit; Dr Joseph Parkinson; Dr Margherita Nicoletti and Tish Morrison, who are both at St John of God Murdoch Community Hospice; Mrs Helen Walker from the Department of Health; Samar Aoun and Jo Hale from the Western Australian Centre for Cancer and Palliative Care; Steven Carmody and Mark Cockayne from Silver Chain WA; Will Hallahan, the executive officer of Palliative Care WA; Mr Dale Henshaw; and all of the people who have helped me over the last three years to better understand this topic and, in particular, the issue of death, dying and palliative care.

**HON SUE ELLERY (South Metropolitan — Leader of the Opposition)** [11.53 am]: I am happy to rise and speak in support of the motion. If I was of a mood to change anything, it would be to note that governments of both persuasions have supported palliative care. One of the important elements of the motion that is before us is contained in paragraph (c) of the motion, which talks about encouraging palliative care to be better integrated as an essential part of all health services throughout Western Australia. Indeed, one of the difficulties that people living outside Perth have is that they do not have access to the fabulous facilities at St John of God Murdoch Community Hospice. An important part of dying with dignity is being able to die next to and with those whom someone is close to and in the community that they have lived their life in. It is important that palliative care services are provided not just in Perth but throughout the state. One of the things that the previous government did, for example, was to fund palliative care beds in places like Carnarvon, Augusta, Morawa and a range of other places, because it is important that if we are to be true to dying with dignity, then it should not matter where a person lives, they should be able to die with dignity wherever they are.

The circumstances were such that in the few days immediately before last Christmas I had to spend some time at St John of God Murdoch Community Hospice. It was a very short period of time. A colleague of my husband was dying. He had no family or other friends or support here, so we stepped in—my husband did most of it. In the short time that he was in the hospice, they were immediately generous and welcoming of us, such that we could take a 42 kilogram dog, Ernie, in to visit Mark; we freaked a few people out as we walked through the corridors, but they were very welcoming of Ernie. Mark's family lived in South Australia. He actually passed away on 21 December. As he was being admitted into the hospice we were trying to make arrangements for his family to come from South Australia. This was a few days before Christmas and we were urgently trying to find accommodation. St John of God Murdoch Community Hospice was fantastic and provided an apartment in the hospice centre for them to stay in. That did not eventuate because he passed away before Christmas, but certainly that short-lived experience was that they were highly professional, very generous and very flexible. It was all about what Mark needed. Mark needed to see his dog before he died, and that was what happened. They were fantastic about that.

Other than that, the sentiments of the motion are entirely sound. I had the opportunity to have a quick look on the internet about the dignity therapy project and how it began. It makes perfect sense to me. An important part of Mark's experience was pulling together all of the important milestone pieces of paper of his life, and he was able to do a little bit of that before he passed away.

The opposition is happy to support the motion; indeed, palliative care is an important part on the spectrum of health services that we provide and we are happy to support what this government has done, what the previous government did before that and to encourage further expenditure in education about this. The more we can talk about and the more we can prepare ourselves for what is absolutely inevitable, the better it is for us and those who we leave behind.

**HON HELEN MORTON (East Metropolitan — Minister for Mental Health)** [11.56 am]: I would like to make a few comments in support of Hon Nick Goiran's motion, mainly because I have a whole lot of responses from the Department of Health on how each of those initiatives is progressing. I want to get some of those on the record. I would like to say at the beginning that when we think about the fact that we are all going to die, that all those people we most love in the world and everybody in fact is going to die, this is an area of work and of consideration that we are probably pleased to be putting a lot of effort into and putting forward initiatives to make sure that we are able to die in a way that is acceptable, peaceful and with dignity. If ever there was a person from whom I learnt about dying with dignity, it was my father, who came home to live with me and died at our house in the midst of his family. He was a great teacher in that role. Of course, it was helpful for him that despite a most debilitating disease that resulted in amputations and various other things, he was able to die

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without pain. It is really important that this government has placed the importance it has on this area, and I agree with Hon Nick Goiran in congratulating the government.

I refer in particular to some of the areas that the government has worked on, with \$14 million provided through the palliative care services fund, in particular the area of rural palliative care across the seven WA Country Health Service regions. WA Country Health Service, in partnership with the WA Cancer and Palliative Care Network, has implemented the rural palliative care model, which provides a framework for structured, coordinated regional palliative care services in core teams in all seven rural regions. The palliative services project fund has enabled the growth of existing palliative care services in the midwest, south west, Kimberley and great southern, and the foundation of new regional services in the other regions where access to quality palliative care was limited and where recruitment difficulties slowed the model implementation. An evaluation of the rural palliative care model confirms the value of rural people's access to palliative care expertise in their local communities with the choice of care and death at home. Of note are the links with partnerships established between the public and private health care systems, the non-government organisations and Indigenous organisations, and the systems for local patient care coordination, as well as access to specialist palliative medical care for advice and mentoring of rural general practitioners. The evaluation confirms that the rural palliative care model should be maintained.

Another area that was mentioned was the two mobile specialist palliative care consultancy teams in the metropolitan area. How that has progressed is that the palliative services project fund, PSPF, has enabled a collaborative—public and NGO—pilot study covering both the north and south metropolitan regions to trial two ambulatory multidisciplinary palliative care teams to be set up to bridge the unmet specialist needs in residential aged care, correctional services, mental health and outer Perth secondary metropolitan hospitals. The teams are complementary to existing palliative care services and provide consultancy, advice and training with the aim of building capacity of staff in the target services. The benefit is the ability to provide quality care outside the tertiary hospitals. Preliminary baseline evaluation results confirm that the unmet need is significant and often complex. The team models and scopes of work are currently being reviewed in line with evaluation findings and modified to ensure a sustainable model is maintained.

The motion also talks about the statewide paediatrics palliative care program under the auspices of Princess Margaret Hospital. Again, the PSPF enabled the sustainability and expansion of the 2008 charity funded palliative care program, which included one nursing position, into a multidisciplinary paediatric palliative care team that provides expertise and coordination to meet the palliative care needs of children with non-cancer diseases, and their families. This service allows families the choice for their children to spend much of their time at home. The service operates as a statewide service from Princess Margaret Hospital for Children with the team working collaboratively within the hospital and with multiple external agencies to ensure that each child receives best quality, coordinated, palliative care. The service has recently been reviewed with the findings revealing steady growth of the service and positive feedback from all groups who interact with it—families, health professionals and community providers. The review identified the significant progress made by the team in providing clinical and psycho-social support and coordination for families, although improvements are still required.

I was also at the session that Hon Nick Goiran talked about by the visiting professor on dignity therapy. I am pleased to say that the government has supported the use of dignity therapy. It will align well with the future plan to expand the initiatives of the PSPF programs to introduce a “continuum for end-of-life” framework to WA. This framework will be important to provide the strategic policy direction to prepare health professionals to be aware of end-of-life needs and/or provide appropriate quality training and care for people when death is expected. Dignity therapy is not currently funded anywhere in WA. I am hopeful that that might be considered in the future.

Another area that was mentioned in the motion is about palliative care being a higher priority in educational programs. The palliative care network has established an expert working group to develop a coordinated approach to palliative care education and training for health professionals working in palliative care specialist services but also to ensure palliative care is built into the curriculum of generalist health professionals at all levels. Work has commenced on a central training plan which will mean less duplication of and more efficient use of resources to provide quality ongoing training programs with pathways for articulation to tertiary qualifications. Education and training will be an ongoing need to support best practice palliative care.

The second last point raised in the motion was about palliative care being better integrated as an essential part of all health services throughout Western Australia. The introduction into 40 Western Australian hospital and health services of the internationally recognised “Liverpool care pathway for the dying patient”—LCP—endorsed for Western Australian needs, has significantly improved the care of patients in the last days and hours of life as demonstrated by an evaluation of that funded by the State Health Research Advisory Council.

The introduction of end-of-life care pathways in health care is a key priority of the national palliative care strategy endorsed by Australian Health Ministers' Advisory Council. Western Australia has gained recognition as the leading state across Australia and has recently gained international acclaim by being invited to be the Australian member of the LCP international reference group. Work with the LCP has clearly identified that palliative care is mistakenly believed to be only available to people in the last few days of life, and as a consequence many patients do not get timely referral and access to palliative care services.

The final part of the motion that I want to give support to is that appropriate palliative care is available for persons with chronic diseases as well as those with cancer and terminal conditions. "WA Chronic Health Conditions Framework 2011–2016" has identified end-of-life care as part of the chronic conditions continuum of care with the objective to ensure informed planning and decision making, with safe and high-quality end-of-life planning and care. The future plan to introduce the "Continuum for End-of-Life Framework" will provide a structured approach to identify timely end-of-life planning and referral to specialist palliative care, diagnosis of dying, and models of bereavement support.

I just wanted to get on record those things that have progressed by the health department, because I think they demonstrate a significant commitment by this government to recognise the importance of palliative care. The government truly does need to be congratulated on this area.

**HON ALISON XAMON (East Metropolitan)** [12.06 pm]: I rise to support this motion. It would be quite difficult not to support it. I congratulate Hon Nick Goiran for bringing this forward. I think the points that have been made and the tone in which this motion has been brought forward is highly respectful and appropriate for an issue such as this. Death, of course, is one of those few things in life that is inevitable. Some of us in this chamber will be subject to very quick deaths, and some of us will not. I think it is important that we talk about what is going to happen for those people whose deaths may be a little bit drawn out. I do not necessarily look at drawn-out deaths as being a negative thing on their own. I have had loved ones who have died over a period of time. It gave me an opportunity to say my goodbyes and to reminisce about the things that matter. An opportunity to say goodbye can be incredibly important. I also recognise that the time of death for many, when it is drawn out, can be a period of great suffering.

We, of course, canvassed a lot of these issues a couple of years ago through the course of the euthanasia debate. One of the issues that everybody in this place agreed on was that there was a great need to enable a more legitimate choice to be made by people who were facing drawn-out deaths and who were concerned about being able to die not only with dignity but also pain free. If we want to be genuine about creating choice for people, we have to recognise that ensuring that palliative care is appropriately resourced and appropriately understood is really part of that choice. People should not have to simply choose between attempting to hasten their death or being in extended periods of suffering. I certainly include emotional suffering in that.

I certainly agree with the comments by Hon Nick Goiran that, as we are facing an ageing population and an increased number of people who are ageing, the pressures that come to bear in terms of costs around appropriate palliative care are going to need to be heeded. It is certainly the case that this will need to be a significantly increased budget line item in the future, simply because of the number of people who will be facing drawn-out deaths. I also note that adding to this issue is the fact that medical technology as it stands means that we are actually enabling people, who otherwise may have died quicker, to extend their lives. Of course, that has the potential to also prolong the suffering of people. We are basically facing a bit of a two-pronged issue—an increased number of people who are going to need to be able to receive palliative care, along with the fact that we have an increased number of people who will have their lives artificially extended, if you like, as a result of medical intervention.

When we debated the euthanasia legislation two years ago in this place, I stood up and made a contribution. It was a very raw time for me. My grandfather had died only six weeks earlier. He had been a lifelong conservative voter and also a Christian. He was also a long-term member of the West Australian Voluntary Euthanasia Society. That debate was very immediate and powerful for me. My grandfather was one of the recipients of the absolutely brilliant care at the Murdoch Community Hospice. That is where he was when he implored me to allow people like him to be able to have choice in relation to the opportunity to die with dignity. That weighed very heavily on my heart, as it does today. I suspect that it will be something that I will carry with me for the rest of my life. I was aware that he was in enormous pain by that point. He had had his life prolonged and had made the most of that opportunity. He had lung cancer that he had contracted as a result of smoking during World War II when he was a prisoner of war. He had stopped smoking upon his return to Australia, but unfortunately all those years later that smoking history had caught up with him. He absolutely made the most of the final months of his life. He insisted that the family have a wake with him there, and so we did. That was really amazing. He also used the opportunity to relay his life story to my mum and my auntie, and they have subsequently written a book of his life. It was just a really powerful time. But in the final two weeks of his life when he was receiving

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intensive palliative care, the reality was that he was in enormous pain and he was ready to go. I know that because he made it clear that if he had his choice, he would have preferred, even for that short two-week period, that that not be the final experience of his life.

I note that dignity is a subjective thing. I think it is fantastic that we are looking at something such as dignity therapy, because a lot of people talk about loss of dignity when what they are really talking about is a loss of support and care around them, and they perhaps see their deaths as being an annoyance or inconvenience. That is tragic and an indictment on us as a community. I think it is incredibly important for people to have an opportunity to get their own sense of dignity in order to feel as though they do not have to prematurely end their lives. But I think we also need to be realistic about what dignity means. People will always have their own idea about how they wish to live in this world and how they wish to die. That is something that needs to be acknowledged and respected as well. I suppose I am saying that a person's right to die is very complex. I am personally not of the view that I support everybody's right to die just because they decide they want to. A classic example would be my vehement opposition to people choosing to take their lives through suicide because they are suffering mental illness or feel that life is hopeless. I make no apologies for holding that view, because I think that when we come into this world, we also have obligations to the people we will leave behind. Having said that, I also acknowledge that when your time has come, your time has come, and that to unnecessarily prolong people's lives and subject people to pain as a result of that is also highly problematic.

Positive action on palliative services is a really important part of all of this. Palliative services need to be made more readily available. I absolutely agree with Hon Sue Ellery about the particular concerns for regional Australians, and I note that Hon Nick Goiran also picked up on this. It is really important that we make sure that palliative care is available to everyone in WA and that not just a select few are able to access these services. It is about creating real choice for people. I do not think that being supportive of an individual's right to die at their own choosing is mutually exclusive from ensuring that people have access to quality palliative services, and that should be promoted as much as possible because it is also a critical part of the language of choice.

**HON COL HOLT (South West)** [12.16 pm]: I want to make a brief contribution in support of the motion and also in support of the comments made by the Leader of the Opposition and Hon Alison Xamon about finding ways that government, through policy or investment, can support our people in the regions to be able to have a quality of death in the place where they grew up, worked or moved to live, surrounded by their family and friends. I want to give a couple of examples of when I have seen that happen, based primarily on the communities themselves and what the communities have been able to drive in offering palliative care services.

The first concerns Donnybrook Hospital. I am sure some members would know that a small group of ladies in Donnybrook has worked for quite a number of years to gather funds and lobby for a palliative care unit at Donnybrook Hospital. When I first started in this position, they came and saw me. They said they were all ready to go, but they just needed a small amount of government investment to bring about that unit at the hospital. Some changes were already occurring at the hospital and also at the seniors' village, and with the high-care units attached to the aged-persons home, and they saw it as an opportunity to have their dreams fulfilled. They had been working on it for a long, long time. They were very passionate about it, as they should be, because it was about them supporting their frail or terminally ill community members who want to stay at home or in their community to receive that final care that makes them feel comfortable in their hour of passing. To the credit of the south west regional health service, that has now happened. They worked with the community and built the palliative care unit; it is all happening. It is a great outcome. That has been driven by government investment on the one hand and, on the other hand, by the will and drive of the community to help support its own people.

Another one I want to quickly talk about is the Albany Community Hospice. Members may not know, but the Albany hospice has an outstanding reputation and supplies an outstanding service to people in the great southern. I know a number of people who have spent their last days there. It is driven by a community committee and its group of volunteers, supported by registered nurses, to provide 24-hour care. They are always looking for volunteers, but the feedback I get from people who work there is that their own quality of life, in supporting others to have a quality of death, is quite incredible and is what drives them. It drives them to go back and volunteer through the experience. Some of them may have been there because of an experience with their own family members and have stayed on because they get such great value and great outcomes for themselves out of it. Albany Community Hospice received as an investment a royalties for regions grant—do not quote me on this—of around \$4 million to build a new hospice to complement the new hospital. Government investment is helping that community organisation to deliver a very valuable and incredibly appreciated service for the great southern and Albany communities. Government can play a great role in palliative care. It is not always about providing every essential service and paying for everything the community wants. When communities are driven to help each other and help themselves, government investment and government policies go a lot further. The dollar is driven a lot further, resulting in better services. I hope the government continues with those investments.

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I am happy to support the motion to continually look at ways to support local people. I am focusing on regional Western Australia as there are specific challenges in providing palliative care services in the towns and communities of regional Western Australia. Some of them are very small; small communities cannot expect an Albany hospice on their doorstep or a Donnybrook Hospital palliative care unit, but they still deserve to have palliative care supported at either home or the local hospital. I support the motion and look forward to seeing continued improvements in those sorts of services in regional Western Australia.

**HON WENDY DUNCAN (Mining and Pastoral — Parliamentary Secretary)** [12.22 pm]: I want to briefly add to what Hon Col Holt has said in congratulating this government on the acknowledgement that palliative care services are needed in regional Western Australia. It is the right policy to, as best as possible, have people reach the end of their lives in familiar territory with family and friends. This is something that has been achieved. I want to point out the first phase of this government's investment in Kalgoorlie Hospital. A total of \$55.8 million has been invested in the Kalgoorlie Hospital upgrade, \$15.8 million of which was out of royalties for regions funds. I was there for the opening of the first phase, which was a new palliative care unit. It provided three large, home-style, purpose-built rooms, each with access to a private courtyard for the exclusive use of palliative care patients. Also in that complex was a separate area for families to have a quiet time, and meeting rooms so that the patient or the family could meet with professional advisers such as lawyers or accountants. The other really special thing about this development at the Kalgoorlie Hospital is that it has been done with a great deal of cultural sensitivity. Each of the rooms has its own private courtyard. The wall of the courtyard is curved to prevent a caged-in feeling. A lot of the plants there are local native plants; in fact, some are local bush tucker plants. This is in recognition that some Aboriginal people will use that unit. Some Aboriginal people come from remote locations, so a hospital environment would be very foreign and quite frightening to them. The work done in that unit to make it culturally appropriate and a place where our Aboriginal people can feel safe and comfortable as they move towards the end of their days is something that the government should be congratulated on.

In Kununurra a couple of days ago, I met with representatives of the Kununurra Rotary Club. The Rotary club instigated the first 100 Women Walk in Western Australia. That walk was undertaken in response to a tragedy during a community event resulting in the death of a young person. During the time that that person was in hospital and the parents and family were gathered around, there was really nowhere for them to go to grieve and support each other in private. The Rotary club came up with this brilliant idea that 100 women would walk 100 kilometres over four days, each of them contributing \$1 000 for the privilege of taking part. As a result, that group raised \$140 000. While I was in Kununurra this week, I saw the Rotary club's plans for what it intends to put onto the new Kununurra hospital site. The plans include not only a quiet area for contemplation and for grieving and support, but also a private and secure outdoor patio so that people can be outside to get a bit of fresh air. It again takes into account the fact that Aboriginal people do not like to be inside in these sorts of circumstances. There are very sensitive and beautiful plans for the new Kununurra hospital. The Rotary club has discovered it does not have quite enough money. I will endeavour to get some support for it to make this project a reality, because it really meets the need of the people in the local hospital.

As an aside, a 100 Women Walk will take place in Esperance this weekend, so the idea has taken off. There has been one in Narrogin. Not quite 100 women, but pretty close to it, will walk 100 kilometres in the Esperance region over the long weekend, finishing up on the Esperance foreshore. I am really proud to say that I was one of the people who helped get that walk off the ground, after having seen what was achieved in Kununurra. The project that the 100 women in Esperance have chosen is a purpose-built playground at Esperance Hospital for people attending either the maternity ward or areas where perhaps someone is in the last stages of life. This playground will also be designed to meet the needs of disabled children. It is an excellent project. I take the opportunity to congratulate the small group of fantastic women in Esperance who have put this walk together. I wanted to take part in the walk myself, being one of the first people to get it off the ground, but I have to be in Kalgoorlie this long weekend because it is the fiftieth anniversary of the establishment of the Kalgoorlie School of the Air. I have my little badge on today—it is pretty horrifying to think that I was one of its foundation students! That was a while back. It should be a great event. As I am not able to take part, I have sponsored a young person to complete the walk on my behalf.

**HON LINDA SAVAGE (East Metropolitan)** [12.30 pm]: I decided to make a few comments because I found it very interesting and quite moving to listen to some of the debate. I commend Hon Nick Goiran for raising the issue of palliative care, which is receiving increasing attention. Great advances in medicine have given us longer lives but they have also given us what could be described as slower deaths. It has been quite well documented that in a sense we die more slowly because of the medical advances that help keep us alive. I have previously spoken in this house in support of the voluntary euthanasia legislation. At that time I think I pointed out that apart from providing choice, countries that often focus on the end of life also put enormous resources into

**Extract from Hansard**

[COUNCIL — Thursday, 27 September 2012]

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Hon Nick Goiran; Hon Sue Ellery; Hon Helen Morton; Hon Alison Xamon; Hon Col Holt; Hon Wendy Duncan;  
Hon Linda Savage; Hon Philip Gardiner

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palliative care. I hope that that will increasingly occur in Australia, with such a large group of people reaching old age.

I noticed that the Senate is currently holding an inquiry into palliative care. It will report on 10 October this year. I understand that it has received a great many submissions, and hopefully that will be the impetus for further funding. I note also that Palliative Care WA is holding a conference in Perth on 5 October.

When listening to members talk, we cannot help but think a little of our own mortality. It made me think more particularly about the deaths of both of my parents and also the deaths of other people I know. My parents died of acute illnesses in their seventies, so they did not have long deaths. Whilst I appreciate that those people who experience longer and slower deaths have the benefit of far better services and pain treatment and understanding and dignity, I am always reminded, as I was recently after the death of someone I knew, that in certain circumstances the death notices will still say “after much suffering”. Despite the advances—hopefully there will be more—death for some people involves great suffering. I have personally seen that.

I did not have anything in particular that I wanted to say. I suppose I was moved to get up because of hearing members talk in such a compassionate way. I was very interested to hear about the availability to talk about one’s life story and life. During the years when I lived in other countries, my mother, who was a great letter writer, sent me an enormous number of news clippings and commentary on the day-to-day scandals, business news and politics of Western Australia, particularly in the 1980s, which would make an interesting book. One day I might try to pull together some of those bits and pieces. Everyone has a fascinating story to tell. Being able to do that and having the assistance to do it is therapeutic and gives one a sense of tying the loose ends of one’s life together. For those who are left behind, it is great to have that family history and those stories. Sometimes people who are nearer the end of their life talk about things in their life that they did not touch on throughout their life. That was my experience with my own parents.

With those few words, I would like to say to everyone that I have listened to the debate with a great deal of interest and commend the motion.

**HON PHILIP GARDINER (Agricultural)** [12.34 pm]: There is only a very short time left for this debate. I was not here for much of this debate. I would like to put one thing on the record about this motion, which was moved for all the right reasons. I was a strong speaker when we discussed the Voluntary Euthanasia Bill 2010 about 12 or 18 months ago. I learnt from that that we should never use the term “euthanasia” again. The example given of Dr Kim Hames’s own experience showed that the elements that comprise euthanasia are an extension of palliative care. In the future that is how we should always refer to the final times of our own health and what occurs. It should always be considered in terms of the most effective palliative care that can be given. If we use that criteria of palliative care, which we use and think about in our normal thinking of how best to care for anyone who is infirm and experiences extreme difficulties with their age when they would really prefer not to continue, that is the extension that we should make to palliative care. I would like to make that brief remark because I think it is quite a different way of considering how to talk about euthanasia. It is not my original thought; it is a thought that came from a very high level person in the Department of Health whom I thought happened to be correct.

Motion lapsed, pursuant to standing orders.