

Hon Michael Mischin; Hon Dr Sally Talbot; Hon Col Holt; Hon Lynn MacLaren; Hon Ken Baston; Hon Ed Dermer; Hon Ken Travers; Hon Helen Morton; Hon Max Trenorden; Hon Matt Benson-Lidholm; Hon Kate Doust; Hon Simon O'Brien; Hon Adele Farina; Hon Robin Chapple

VOLUNTARY EUTHANASIA BILL 2010

Second Reading

Resumed from an earlier stage of the sitting.

HON MICHAEL MISCHIN (North Metropolitan — Parliamentary Secretary) [5.03 pm]: I was dealing with the subject of the inevitable creep in the legislation that would allow it to embrace areas not currently contemplated by the legislation; that is, the fitting-in of patients to the criteria as has happened in the Northern Territory and other jurisdictions. I suggest that it is all very well for Hon Alison Xamon to say that she would never countenance laws that would extend voluntary euthanasia to, say, the mentally ill, but the law that she supports allows for that possibility. To ignore that possibility by resort to an individual's right to die as a justification for the legislation is, with respect, an abdication of our responsibility as legislators. We must ensure that legislation of this type is not open to abuse, if that is a possibility in the way that it is framed.

Other ways that the legislation may creep to embrace other circumstances is raised by the question of why it is limited to physical pain and suffering. Surely mental anguish from depression is no less distressing, debilitating and deleterious to the quality of life and it is far harder to relieve through medication. Why should voluntary euthanasia not be extended to suicide at request? Why is it that only someone who is physically ill is able to avail themselves of relief from suffering? Mental illness can be much more debilitating and destructive to the individual than some physical illnesses. People who are suffering schizophrenia, for example, have their lucid moments but their lives can be a misery knowing the damage they can cause to others and themselves. Why should they be excluded from the benefit of having their suffering relieved by having access to assisted suicide? What of those who are unable to make informed decisions; the incapacitated or mentally retarded? What about people of 20 years of age as opposed to 21 years of age, as currently contemplated by the bill? What about children? Why should children be condemned to many, many years of suffering until they reach the age of majority at 21 before they can be relieved of their suffering? Should someone perhaps be appointed to make those decisions for those who are incapable or too immature to make the decisions themselves? Perhaps we should get an expert to decide who should live and who should die under this legislation. Therefore, the issues are not as simple as resorting to reference to one's own family or one's own experience or personal preferences. There are consequences to society generally, and I suggest, with respect, an inevitable push to include people into the benefits of it and a relaxation of the bounds of this legislation. If we are to extend the legislation to those who may be suffering but cannot make decisions for themselves, what stops it from becoming eugenics? Will the availability of relatively cheap assisted suicide discourage public investment in the far more expensive field of hospices and palliative care? It is said that that has not happened overseas, but I do not know. I do not know what the evidence is for that and I do not know whether, generally, members of this place can say that; we have not had any evidence of that that we are able to assess. Would those who would not wish to avail themselves of suicide be increasingly regarded as selfish for continuing to be a burden on their families and friends and on the community? How does one address the issue of vulnerability of patients who may be under influence? It is all very well to legislate to say that a doctor has to be satisfied that they are not, but how does one attend to it? How does one ensure that they are not?

These are not idle speculations; they are the fruits of experience in other jurisdictions. Regrettably, experience has shown us that not all doctors and not all nurses can be trusted with patients' lives even now. As presently advised, I do not have confidence that they ought to be given a licence to kill and to decide whether someone ought to die. By way of example, I refer the house to two articles recently published. One article was on page 42 of *The West Australian* of Friday, 11 June 2010 under the headline "'Consent lacking' in euthanasia", which states —

Almost half of deaths by euthanasia in Belgium have involved patients who have not explicitly requested their lives to be ended by a doctor, a study has suggested.

A fifth of nurses interviewed by researchers admitted that they had been involved in the euthanasia of a patient based on the "assumption" they would want to die. Nearly half of the nurses—120 of 248—admitted they had taken part in "terminations without request or consent".

Euthanasia has been legal in Belgium since 2002. It accounts for 2 per cent of all deaths annually. The law states that patient consent must be given and that doctors must carry out the procedure.

But the study published in the Canadian Medical Association Journal shows that the rules are routinely flouted and doctors often delegate administering fatal drugs to nurses.

Extract from *Hansard*

[COUNCIL - Wednesday, 22 September 2010]

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“By administering the life-ending drugs in some of the cases of euthanasia, and in almost half of the cases without an explicit request from the patient, the nurses in our study operated beyond the legal margins of their profession,” the report said.

British anti-euthanasia campaigner Peter Saunders said: “Wherever you draw the line, people will go up to it and beyond it.”

We know that as a matter of experience.

The other article I wish to quote from is in *The West Australian* of Monday, 21 June 2010. On page 27, under the headline “Yes, I killed my patients: doctor”, it reads —

A British doctor cleared of murdering three patients has broken his long silence to admit that he did hasten their deaths as well as those of dozens of others in his care.

Dr Howard Martin said he gave what proved to be fatal doses of painkillers to elderly and terminally ill patients.

But he said he only acted out of “Christian compassion” and was merely trying to limit their suffering rather than “playing God”.

It is astonishing that he decides who ought to live and who ought to die, and he is not playing God. It continues —

He disclosed that, in two cases, he hastened the deaths of patients without their permission and one of those to whom he administered a final injection was his son, Paul, 31, when he was dying from cancer in 1988.

Dr Martin, 75, spoke out as the General Medical Council struck him off for professional misconduct, ruling that he had hastened the deaths of 18 patients in “egregious, despicable and dangerous” conduct.

He accepted that his confession put him at risk of “spending the rest of my life in prison” if it prompted police to reopen his case.

He did not talk about what he did during his triple murder trial, subsequent inquests or the GMC hearing.

But Dr Martin said he decided to speak out to call for the reform of a system of care, which—he claims—takes the soft option of confining the terminally ill to hospitals and hospices rather than allowing them the dignity of dying at home with loved ones.

“A vet would put a dog down but under the current system a doctor is not allowed to take positive action to help a patient in a humane way,” he said.

“I don’t believe I’ve killed any patients. I believe I’ve made them comfortable in their hour of need.

That is a euphemism for murder —

“But I am deemed to be arrogant because I used my discretion. They want to extrapolate that to say I’m choosing to kill people. It’s not like that. The patients are about to die and I make sure they are comfortable.”

The article goes on to say that Dr Martin was suspended. Interestingly, the article states —

Dr Harold Shipman, Britain’s most prolific serial killer with an estimated 258 victims, once briefly worked as a locum at Dr Martin’s practice.

There are some medical practitioners who do not need a licence to kill to do it, yet what we are saying is that people at their most vulnerable—when they are depressed and when they are uncertain and fearful of the consequences of their illness—should merely go to a couple of doctors who can sign some forms and give them license to die and license themselves to kill, and that that be recorded as a consequence of the illness, not a deliberate life-taking.

I am seriously concerned about the implications of such a fundamental change to how society will value life. I am concerned about the potential for the law to be abused to the disadvantage of patients at a time when they are spiritually and psychologically vulnerable. I am concerned that such a law may provide the pretext for society to neglect its obligation to provide suitable palliative and other care for its citizens. I am concerned that such a change to the law ought to be made only on the basis of rigorously tested evidence. That has not been done. We have pressure groups, for example, saying that the experience in other jurisdictions points both in favour of and

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against such a change. This house has not been able to evaluate that evidence, yet we are being asked to make a decision on it. As presently advised, the bill as drafted is a path upon which I am reluctant to lead society in the absence of compelling evidence that it is the right course. I am unable to support the bill.

HON SALLY TALBOT (South West) [5.14 pm]: As a number of honourable members have noted, this is a difficult debate to have, not so much because the actual issues involved are difficult but because the very subject of death is difficult. It is painful and it is complicated to talk about these things. I have been collecting material for some months, as I would imagine most members in this house have, if not over a period of a few years knowing that one day we would have this debate. I want to start my comments by referring to an article I found particularly interesting, and have come back to a few times over the past 12 months. It is a piece by Gail Bell published in *The Monthly* in April last year. Gail Bell is a pharmacist. She is reflecting on what happens to us as we go into middle age and we seem, inevitably, to have more conversations about death and dying. She says this —

We each have an entry point into the vast euthanasia emporium. For years I've deflected all attempts by others to draw me inside the building, preferring my own private Neverland illusions—but the pressure to step off the footpath and move through the big revolving door has been mounting.

I am sure a few members in this chamber will agree with me that that is a feeling that has been experienced in this chamber over the past 12 months or so.

These are not discussions that we enter into easily or with a particularly light heart. The reason I go back to the Gail Bell article quite often is that she is able to show, by comments such as the one I have just quoted, how complicated this issue is and how deep our resistance to talk about it is. I suspect at the heart of the complexity is the fundamental question whether death itself should be something about which we can exercise choice. It is a question without an easy answer. When I lectured in the introduction to philosophy course at Murdoch University, which I did for some years, we framed the course around a series of what we saw as the crucial questions of life: does God exist; do only humans matter; is the world a dream? There was inevitably at least one student every year who came to me at the beginning of the course and said, "Just give me the answers and the workings so I can prepare for the exam"! These are questions, as a number of honourable members have noted, without straightforward yes or no answers. However, in this particular context of a parliamentary debate we are required to vote only one way or the other. I want to outline to the chamber in the next little while why I will support the Voluntary Euthanasia Bill 2010.

It has been very interesting listening to the debate so far. I am sure we will go a considerable way into the evening with more debate tonight. I have noticed that mostly we seem to be more comfortable, as people usually find debating these difficult ethical questions, talking about things hypothetically. It is much simpler to talk about things in the abstract. It is much simpler to talk about situations in which we do not actually know the people involved. One of the things I have noticed is that even some honourable members who will oppose the bill might be able to agree that, taken hypothetically, the proposition is sound. It depends partly on how one reads the basic proposition. The proposition that Hon Robin Chapple has invited us to consider is that we should think about the fact that to help someone who is dying choose how he or she dies is not a criminal offence. If that is the basic proposition—I would be interested to know whether others later in the debate want to challenge that—I suggest to the house that some members who will oppose the bill might support the basic proposition as long as it is taken hypothetically. But it is when we get into speaking about the actual circumstances, which we have confronted ourselves or of which we have personal accounts from people we know, that things get a little more complicated. This is always the case. It is why all intellectual musings about ethical problems are couched in the abstract. It is why we are much more comfortable dealing with hypotheticals than we are with the complexity of everyday life. It is why it is easier to talk about things like how many angels can dance on the head of a pin than what life is about and what it means to live a good life.

Another thing I have noticed listening to the debate so far is that the people who have relied on personal accounts to make their point in opposing the bill have missed the specific focus on the very narrow range of circumstances to which this bill would apply. I have heard a number of members who support the bill, including Hon Sue Ellery, say that this might be one of the shortcomings of the bill and why some of us who are in favour of euthanasia hesitated when we saw the very narrow terms in which Hon Robin Chapple had framed the bill. The messy reality of everyday life is that people do choose to end their life. It is far too abstract to say that it is wrong to kill. The reality of the way we live and the way that our relationships play out in everyday life means that sometimes we have to make very hard decisions. Often those decisions are made on the basis of love and care. The reality is that people do choose to die. From a very fundamental point of view, I am in favour of legislation that enables euthanasia because people are doing it anyway. It is much easier to do if someone has

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money and resources and is well connected. From the bottom of my heart, I believe that people should not have their choices restricted because of the way their life has turned out. On the basic principles of equity we should look to extend the rights that are involved in euthanasia to everyone who is involved in that decision.

I have referred to the very narrow range of circumstances in which the bill would apply. As I understand it—I am interested to hear my understanding contested specifically if members disagree—the terms of reference apply to a suffering terminally ill person who has made a highly specific request that has been judged to be a consistent and rational request to die a gentle and peaceful death and they apply to a request for the person to decide when death will occur.

It is very important to be clear about what we are not discussing in this bill. As I said, it is a very narrow range of circumstances, the provisions of which will cover only a few people. I will talk about the things that I understand we are not talking about. The first is when someone is motivated, often out of a loving desire, to put someone out of his or her misery. That phrase is often used about the way we treat animals. We put an animal out of its misery, so why would we not do the same for humans? I agree with many members who spoke against the bill that this is not necessarily a provision for which euthanasia should apply. More specifically for this debate, that is not covered by the terms in this bill. The problem with the sentiment of someone who says, “I want to put you out of your misery” is that it may mask a sentiment that is much more about “putting me out of your misery”. Many honourable members have referred to that when talking about their own experience. I agree that it would show quite a remarkable capacity of introspection if someone whom a person loved very deeply was dying was able to unpack his or her emotions sufficiently to say, “I want me to be put out of your misery.” Nevertheless, that is a debate that we may well have to have at another time because that circumstance is not covered by this bill. People who are suspicious of the emotional response that says, “I cannot bear to see you suffering like this” can put aside their concern because that is not what this bill is about. It is not about that because the bill provides that the decision is made by only one person, and that is the person who has been diagnosed with a terminal disease and who is dying; the decision is not made by the people who are caring for the person who is dying.

This bill is not about non-voluntary euthanasia, which is sometimes confusingly called involuntary euthanasia. That sounds as though someone has made a mistake so I prefer to call it non-voluntary euthanasia. I understand that many members and people in the wider community would have concerns about that type of euthanasia. However, let us not kid ourselves; it is well documented that non-voluntary euthanasia exists in our society. Many medical practitioners and people who are engaged with people who are dying, both professionals and those who care for family members, have had the courage to talk about those experiences. I say again that those circumstances are not covered by this bill. My mother was diagnosed with a condition called progressive supranuclear palsy in around 2001. That condition caused her to lose most of her physical stability and meant she was constantly falling over and hurting herself. It also involved a dementia that was unlike Alzheimer’s dementia. It was a particularly distressing form of dementia because she maintained awareness of what was going on around her but became progressively isolated from the world. People who suffer from a condition similar to my mother’s would not be able to opt into the provisions of this bill. Within a few months of my mother being diagnosed, my father had power of attorney over all her affairs. People in that situation would not be able to avail themselves of the provisions of the bill. That is a very important consideration because dementia is a rapidly escalating condition in our society. I know of the distress that is caused to families by having to care for people with dementia. A concern that is frequently raised against making euthanasia more freely available is that families will use it as a convenience. I say again that no-one in that situation will be covered by this bill.

This bill is also not about passive euthanasia, which is when treatment that would prolong a life is withheld or withdrawn. That means it will not apply to cases, for example, of a person who has an anencephalic baby—that is, a severely disabled baby who will never recover, because a baby born without a brain has no future. These provisions will not apply to a child in that situation. Similarly, because it is not about passive euthanasia, it is not about people in a coma. This legislation will not capture some of the most recently well-publicised cases that people who are opposed to euthanasia use to support their cause. I am referring to people who have been in a coma for many years and have regained consciousness and reported that they have had a degree of awareness all that time. I am making these points in the context of saying that a remarkably narrow and specific range of people will be covered by this bill.

Perhaps most importantly, this bill is not about people who are not dying. That means that the provisions in the bill will not be available for people to decide how they wish to die at some point in the future unless they have already been diagnosed with a terminal illness and are dying. It also means that people who have a disease that is not classified as terminal will not be able to avail themselves of the provisions of the bill. We were all reminded the other day about the terrible case a few months ago of a man who had to starve himself to death. The

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provisions of this bill would not apply to him because, as a quadriplegic, he was not diagnosed as dying because he did not have a terminal disease. I make this point specifically in response to some of the points made by the people who visited Murdoch hospice recently; namely, that this bill will not be applicable to people who are going through that state of shock and extreme anxiety felt by people who have just been told that they are dying. Contrary to the suggestions that have been made by some members in this debate, there is a cooling-off period. I have been with people recently diagnosed, and I know about the concerns for somebody who is numb with shock saying that he or she just wants to die right now. However, the fact is that nobody who is still in that state of shock and anxiety would be allowed to access the provisions of the bill. I will say it again: it is a remarkably narrow band of circumstances in which the provisions of the bill can be called on. That is one of the reasons I, along with some other members, perhaps would have preferred a bill that was a little more wide ranging.

It is important to look at some of the ethical frameworks that we draw on when we make this sort of decision. Without getting too far into the long grass of technical considerations about ethics, which is something that people used to pay me to do and which temptation I will now resist, it is important to stress at the beginning that I am talking about not what we do, but how we might choose what to do—in other words, what we might consider on the way to making a particular decision. To put that in very concrete terms, what I am about to talk about now is not whether I would choose voluntary euthanasia, but what might I think about in making the choice. I will quickly go through a couple of the ways that we have historically, in terms of our intellectual traditions, made those decisions.

The first is in terms of some kind of global imperative—reduced in colloquial terms to “do as you would be done by”. It is more fancily called the categorical imperative, which can be expressed as acting in such a way that all one’s actions can be universalised. That is how, for instance, we have attempted to argue in the past that lying is wrong. Members will see the attraction of this sort of argument; that is, if we could say that killing people is wrong or that taking a life is wrong, including our own, we would be able to condense this debate into about 20 minutes. It is because even those people who would like to be able to argue in that way realise that messy everyday real life is more complicated than that, and that it takes some hours to discuss these things. Traditionally, we wanted to say that lying is wrong because if we say that lying is right, we lose all sense that there might be a possibility of telling the truth. As soon as I say that it is morally right to lie, I will never know when the other person is telling the truth because the very concept of truth telling drops away. However, the famous philosophers who have pushed that line have found themselves in very deep and very hot water. For example, Immanuel Kant used to argue that lying was always wrong. He was called to task by a fellow philosopher who asked Kant what he would do if a person knocks on his door saying that someone is trying to murder him and asks to be hidden. He asked Kant whether he would tell the truth if he took the person into his house and put him in the broom cupboard and then, hearing a second knock at the door found himself faced with the would-be murderer who asks, “Are you hiding the person I am trying to kill?” And Kant—the poor man was very grumpy at that stage of his life because he was suffering from gout and all sorts of diseases that made him very unhappy—said that yes, it was still wrong to lie and therefore he would have to say, “Sure; he is in the broom cupboard.” He effectively undermined a great deal of his life’s work by responding in that way.

In that relatively light-hearted example, members can see that it all depends on the way that we phrase the question, and I attempted to frame that question at the beginning of my speech. If the question is, “Should helping someone who is dying choose how he dies be a criminal offence?” I think that we will get a different answer from that if the question is couched in terms of a more question-begging phrase, which talks about whether it is right to kill people or, even more extremely, whether it is right to insist that people euthanase themselves rather than avail themselves of expensive palliative care. It depends how the question is phrased. I think that the ethic of duty, or deontology, falls down because it depends on how the question is phrased.

Then we come to the ethic, in a vaguely historical progression, of utility. This is the ethic most often used by advocates of euthanasia. However, it is not one that I want to use and I will explain why. The ethic of utility or utilitarianism is basically about reducing pain and therefore increasing pleasure. It does not matter which way round we put it because utility is what is supposed to be increased and utility is expressed as increasing happiness. This argument is a classic one in terms of the way that we have traditionally talked about these matters. This argument is very, very attractive in the abstract hypothetical sense. By simply writing an equation on a piece of paper, the degree of pain suffered by a person can be added up on one side of the page and the lack of pain, if not happiness or pleasure, that will be brought about by the ending of this person’s suffering can be added up on the other side. People have tried, in serious intellectual arguments about these things, to give each item a numerical value and total the columns at the bottom of the page. It looks just like an Excel spreadsheet and it takes away a lot of the angst—at least it does in an abstract hypothetical sense. I know somebody who

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made a decision in this way—not about ending a life, but about ending a marriage on that basis. Please do not think —

Hon Giz Watson: Was it a good result or a bad result?

Hon SALLY TALBOT: I think that it was a good result for her; although I do not know that she lived comfortably with the way that she had done it in the years to come. However, it did solve the basic problem for her.

Please do not think that I am drawing on farfetched academic abstractions in making these points, but to think that we can just do a straightforward calculation about reducing pain and increasing pleasure is of course basically offensive when it comes to anything other than a hypothetical argument. Of course, there is a very important sense in which that utilitarian principle is compromised by real life. We never think about dying people in those ways. In actual fact, we probably do not think about dying relationships in those ways. Nevertheless, the intellectual attraction of going down that path is clear. Not everybody has been as circumspect as I am in embracing these utilitarian calculations. The problem is that one can be led into very, very long grass, as people such as Peter Singer have found out. Peter Singer, an admirable thinker who has contributed an enormous amount to our intellectual life with his animal rights work, has gone so far as to apply utilitarian principles to anencephalic babies. He has found himself in very, very long grass and has been accused of all sorts of things. That is very dangerous ground.

There is a third way of looking at these things and it is the way that I find most attractive. I have spent a substantial part of my life trying to develop an ethic around this kind of approach; namely, the ethic of care. The ethic of care starts with the basic premise that all these other philosophical abstractions are just that, philosophical abstractions, and that the attempt to relate them to real life shows, as I have attempted very briefly to do, either that they do not work or that we end up with a contrivance that we cannot live with because it does not make ethical sense in terms of our real relationships. The ethic of care looks at that concrete messiness of real life, at the complexity of human relationships, and starts by trying to form some ethical principles around that concrete messiness.

Therefore, the question I pose through the ethic of care framework is: are there people with terminal illnesses who want to choose how they die? I do not think that we can argue that there are not such people because many of them have been prepared to record their stories—not so much for the purpose of this debate today, because it is not a new debate. Certainly, if we look at the history of the debate, people with terminal illnesses want to choose how they die.

My next question is: can we imagine that this is a choice that we might want, one day, to make? Remember, I have said already that this is not a decision that we can make today—assuming there are no honourable members sitting here today who have been diagnosed with a terminal illness—as a result of the provisions of this bill. But can we imagine that, one day, we might want to make that choice? I am not even asking members what they would choose. I am just asking: can we imagine that, one day, our partner, or our child, or someone about whom we care very deeply, might want to make that choice? I then ask: will we then be prepared, when a person has made that choice, to deny that person that choice and tell that person that that choice is wrong? I ask those questions because that is the reality of the law as it stands today. As I have said, will we be prepared to take away from people who have a terminal illness the decision to choose how they will die? I think it will be glaringly obvious to anybody who has been listening to what I am saying that there are such people. I can imagine that this is a choice that, one day, I might want to make, or that somebody I love might want to make. What we do to those people now is we either make them die alone or make them depend on others to break the law. This is another reason that I want to go to the Gail Bell article. As I said at the outset, she is a pharmacist. Later in the article she says —

In the conversations I've been drawn into, I'm not asked to pull the plug.

She is talking about her personal conversations with her friends. She continues—

The challenge is presented as an extension of my regular line of work, pharmacy, *We'll look to you for a dose of the right stuff when the time comes.*

That is what we will force people to do if they have made that choice, or if they think that choice might be one that they will want to make in the future. What we say to those people now is, “If you make that choice, either you will have to depend on others to break the law, or you will have to do it yourself; and, if you do it yourself and you do not want to implicate others, you will have to do it on your own.” That is not something that I am

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prepared to contemplate. I cannot see how it could be right in any sense to force that onto people as a result of a decision that we make in this place.

It is glaringly obvious that some people do not get the chance to choose how they die. They do not get the chance to choose how they die because they die suddenly in an accident, they are in a coma, they are suffering from dementia, or they are for some reason in that very broad category of people who will not be covered by the provisions of this bill. So, I again make the point that we are dealing with a very specific set of circumstances. Some people just do not get the chance to choose whether to end their lives; and some people who are given the choice will choose not to end their lives. That is why I made the point earlier that the bill does not come anywhere near those people who are in the Murdoch hospice. Those people have made the choice—not in a legal sense, but in terms of their actions—that they are not going to kill themselves by some means, and they have chosen palliative care. Palliative care is a form of caring for the dying, just as euthanasia is a form of caring for the dying. I have cared for a person who was dying of breast cancer. She had ample opportunity to end her life, and she chose not to do it. When she did eventually die, I would have given anything for just one more day, even one more hour, with that person. But she made the choice just to let things happen; and, if she had asked me to help her, that would have been a decision that I would have had to make at the time. But she made the choice not to do that. So she is in that second category of people.

Fundamentally, what we are talking about today is whether we will respect the decisions of those who decide that a gentle and peaceful death at a time that they choose is the way they want to end their lives. I cannot vote to deny anyone the right to die in this way—not you, and not me. That is why I am supporting the bill.

HON COL HOLT (South West) [5.45 pm]: I also want to speak on the Voluntary Euthanasia Bill 2010. I, like many members in the chamber, have had the experience of dealing with a loved one who has had a terminal illness. My father died three years ago from bowel cancer. He was going through treatment, and his condition was deteriorating by the day, and eventually I rang his doctor and said, “I think dad has had enough. I think you should stop the treatment, and you should send him home and make him comfortable and take away the pain, and we will nurse him from there.”

I have been listening to this debate with a great deal of interest. Some compelling arguments have been put on both sides of this debate. It really comes down to almost a moral and ethical decision by all of us, based on our values and how we see life—and how we see death, probably. Hon Dr Sally Talbot made some incredibly important points about that choice. For me, the argument can be distilled to choice. I think people should be given a choice about their own life. I think people should be given a choice about how they live their life and what they do with it, so long as they do not interfere with other people. People probably should also be given a choice about how they end their life. The one important question that has not come up during this debate, or that I certainly have not heard during this debate, is: do we have the right to ask another person to end our life? That is the important question that we need to ask. For me, the debate can be distilled to that point. I am very interested to hear a response from Hon Robin Chapple to that question.

During this debate we have talked about compassion and dignity, and about people asking their physician to end their life. I know that there are doctors in the community who will take up that challenge. However, there are also doctors who will say no, they will not do it, because they are opposed to euthanasia. If a person asks his or her physician and the physician says no, what will happen to that person in terms of—I do not want to use the words “shopping around”—finding a physician who will do that? That is one of the important questions that must be raised in this debate. People who are dying want to be surrounded by their loved ones, and, I would suggest, a physician whom they trust as well. To me, that opens up another series of debates. That is all I want to say. I want to pose the question: do we have the right to ask another person to end our life?

HON LYNN MacLAREN (South Metropolitan) [5.50 pm]: I rise to support the bill. I acknowledge the many people who have been here over the past two days in the public gallery, demonstrating their concerns for both sides of the debate no doubt. I also express my appreciation to all those who have written so many letters and emails to us expressing their views and sharing parts of their lives with us to enable us to make wise decisions. I note that, as was very eloquently put the other night, the opportunity to effect significant policy changes does not arise very often. I think that this is one of those opportunities, and I thank Hon Robin Chapple for providing us with the opportunity to be able to look at one of those really serious questions in life and reflect on it and try to make wise decisions.

In providing my statement of support for this proposed legislation to facilitate voluntary euthanasia in Western Australia, I also want to respond to some of the comments that have been raised over the past two days. Like many members, I have had quite a few letters and quite a few emails that are opposing the idea of euthanasia, on the grounds that it is apparently “killing” someone. With very few exceptions, I can summarise these emails

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briefly: life is precious, pain and suffering have a purpose, and legal safeguards cannot be relied upon to protect the vulnerable. That is how I sum up those messages. The letters in support of euthanasia, with very few exceptions, are detailed explanations of personal experiences that are complex, real-life situations. Many members may have received this email. I want to read it into *Hansard*. I sought the permission of Chele Wickramasinghe to read it in, because I think it illustrates the very complex situation that we are dealing with. It reads —

Hi Lynn

I am writing to let you know that I am 100% behind a euthanasia bill being passed. I think it's totally archaic that people don't have control of their lives in situations where there is no hope. Anyone suffering a permanent disabling or terminal illness and/or no quality of life should be able to decide they have had enough and pick the time and the place for a dignified ending. You'd be in court if you let animals suffer the way humans are left to suffer. Everyone doesn't have to make use of it, but everyone should have the option. It's time for politicians to make this possible.

I missed seeing my mother before she died of cancer. She lived in Sydney and I was living in Melbourne with a toddler, so it wasn't easy for me to just up and travel. If she had had a choice of when her life should end I could have known when the time was and been there to see her. I never got to say goodbye and that will haunt me every day of my life until I lose my faculties.

My sister is in an institution in another state with early onset dementia. I know it's not what she wants. She and I both have the Huntington's disease gene which means that we will both one day be vegetables. As we both share this gene we have had numerous discussions on the subject of euthanasia. I know it's what she would want. Sadly she has been dealt a blow of a double whammy of getting dementia before the Huntington's and will be stuck in an institution until she dies who knows when. She is only 58.

Having the Huntington's disease gene, although I am perfectly all right now, I know if something else doesn't take me beforehand, I will end up a vegetable and unable to take care of myself. There is no way I want to be alive when I am unable to look after myself and I certainly don't want to waste my children's inheritance by being placed in an institution with no independence to be spoon fed food which has been specially prepared to prevent me choking and to be washed by other people and all my dignity taken from me.

I am certainly hoping a choice of euthanasia is available when my time comes. Please make it possible.

Kind regards

It is apparent from my research that should this bill come into effect as a law, it will make a world of difference to a very small number of people, and for those who oppose the changes it would bring about, there would be no discernible difference in the life that they lead. Those who oppose euthanasia never have to take up that option. They might never need to use it, but to deny another human being who has suffered for any length of time the right to die in peaceful circumstances, I say, lacks compassion. Death comes to each of us. It may come like a thief in the night, or meander like a slow-moving river, slipping underground and then breaking the surface, rushing over stones on a steep decline. It may peel back the layers of consciousness until nothing but awareness in itself remains, or it may linger years on end, painfully in sorrow. Death comes to each of us, but we may have a choice of how to meet it.

Framing my own views on the matter, I reflected, like many other members, on cultural ideologies and my own personal experiences, and they are very similar to Hon Col Holt's experiences that he just shared with us. In looking at cultural ideologies that we are surrounded by, there are some home truths, such as everyone dies. Religions and philosophical traditions evolve to make meaning of life and to find ways to address the simple truth that everyone dies. One of the questions being posed in the debate is: what is the quality of life and how does that affect death? Christians hold a wide range of positions regarding end-of-life matters, and we have heard that from many speakers, but I felt that to quote from an email received from Reverend Ken Devereux would be helpful at this stage, to present one of the views of Christians. Again, I have sought his permission to include this in *Hansard*. It reads —

Whilst many Christians take the traditional view of affirming the sanctity of life in such a way that we can never contemplate allowing someone to deliberately and legally end their own life, I would like to suggest that the God-given responsibility we have for ourselves and one another can be understood to give us the scary freedom and responsibility to consider compassionately providing responsible

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mechanisms whereby someone can decide to bring their life to an end in a caring, safe and respectful manner.

The reverend referred me to Andrew Dutney's book *Playing God: Ethics and Faith* from HarperCollins. He wrote that it made a helpful introduction to a range of Christian positions regarding the sensitive issue of decision making. I would like at this time to reflect upon my own personal experiences and how they relate to this. I am very well versed in the Christian tradition. Having been baptised and christened in the Episcopal Church, I was delighted to hear from Hon Philip Gardiner that most followers of that faith are in favour of this type of legislation. I was a star pupil at Sunday school at St Christopher's in Wichita, Kansas. I delivered homilies from the pulpit at St Timothy's Church in Apple Valley, California. My spiritual education is ongoing, and it has included studies in other faiths and other practices, including Buddhism. One enduring lesson for me is compassion. Alongside my mother I cared for my dying father, with the support of home hospice care in his final months, as cancer ravaged his body and his mind. My father may never have chosen euthanasia for himself, and I would ever defend his right to make a choice to fight to the last end of his breath. Having been so close to this experience, I, however, want the right to make this my own choice should I find myself in circumstances in which it is possible.

When Hon Robin Chapple sent us this bill, I did a bit of research and looked around. I met with Chief Minister Marshall Perron when he visited us in August. I learnt from his experience about how he was able to manoeuvre a bill through a very conservative Parliament because of his very compassionate and rational treatment of a subject that was affecting all the members there. I really appreciated the fact that Marshall Perron was able to visit us to offer his wisdom and his experience in our decision making. I know that other members here also took that up.

Because my mother has now relocated to Oregon, it was of particular interest to me as she is now getting a bit older. I do like to know what is happening in Oregon as far as hospice and palliative care go. As members all know and will have been advised, Oregon is one of the places that have voluntary euthanasia legislation. It is also important to note that hospice care in Oregon is rated as one of the best in the United States of America. The physicians in Oregon have attributed an increased knowledge in palliative care to the passage of this act. More than any other state in the USA, Oregonians suffering from terminal illness are dying in the comfort and security of their own home with the aid of hospice care. A study was specifically aimed at doctors' attitudes about, and experiences with, end-of-life care since the enactment of the Oregon act, which put in place voluntary euthanasia laws 10 years ago.

Sitting suspended from 6.00 to 7.30 pm

Hon LYNN MacLAREN: Before the dinner break, I was about to go into the system in Oregon in a bit more detail. Although voluntary euthanasia is illegal in Australia now, there are other jurisdictions that have precedents for maintaining some kind of legal structure for voluntary euthanasia, and Oregon is one of those areas. In the state of Oregon, physician-assisted dying has been in place for 10 years. Every year there is an annual report to the legislature. This report indicates that it is not a slippery slope with lots more people joining every year; in fact, one-third of the people who went through the assistance safeguards and procedures and received the drugs never actually used them in 2009. It is important that the use of euthanasia drugs in Oregon is reported to the legislature annually; therefore, there is some method of scrutiny of how the system is working. I note also that the provision for regular reporting is included in this bill.

I will make a couple more comments about the system in Oregon. I believe it was Hon Brian Ellis who raised concerns about doctors and how they would be impacted on by this legislation. Members may even have seen on the news tonight before they returned to the chamber that our Minister for Health commented on his own practices as a physician and the administration of pain-relieving drugs to terminally ill patients. The study in Oregon that I am referring to was aimed at doctors' attitudes towards and experiences with end-of-life care since the enactment of that act. It concluded that rather than the availability of the drugs for physician-assisted dying diverting attention from efforts to improve care for the dying, Oregon doctors who treated the dying had endeavoured to improve the ability to treat those patients. A statutory authority, the Pain Management Commission, was established to administer pain management education programs for licensed healthcare professionals who treat patients with chronic or terminal pain. Not only is the system improving health care and palliative care, but also it is working to reduce the number of people who might initially want to access voluntary euthanasia, because they end up passing away before they use the drugs that they have obtained.

I want to make a couple of points about the Netherlands, which many members have mentioned at various instances. I believe Hon Robin Chapple will explain the Dutch system in some detail, but I think it is worth noting that after many years of voluntary euthanasia being in place in the Netherlands, the Parliament and the

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citizens of the Netherlands continue to support that system. They still think that it is worthwhile to continue to support a system that provides that kind of assistance. They have the most transparent reporting of any of the systems that we know, which is why there is so much evidence about how well the system is or is not working. Only one study in Australia was designed specifically to replicate the information that is gathered in Holland. The study by the Centre for Human Bioethics at Monash University was published by *The Medical Journal of Australia* and found that the incidence of Australian doctors ending life without the patient's request was five times higher than in the Netherlands.

I, too, am a Peter Singer follower. The history of Peter Singer's thoughts on voluntary euthanasia is chronicled in various texts. The text I will quote from today partly identifies what we are not looking at, along the lines of Hon Sally Talbot who very cleverly outlined exactly what we are not doing by passing this bill. Peter Singer breaks euthanasia into three types: voluntary euthanasia, when a person is cognisant and aware at the time and chooses this option; involuntary euthanasia, when a person is not cognisant and aware but has at some time indicated he wishes to die and the action is carried out only to cease suffering; and non-voluntary euthanasia, which is, of course, an ethically controversial situation when the person is no longer cognisant or aware and cannot make a choice. Neither of the last two situations is what we are talking about. Quite a few safeguards in the bill protect us from going anywhere near those two choices. Finally, I will quote from Peter Singer's *Writings on an Ethical Life*, which reprints part of the "Justifying Voluntary Euthanasia Essay" from *Practical Ethics* and states —

It may occasionally be right to prevent people from making choices that are obviously not rationally based and that we can be sure they will later regret. The prohibition of voluntary euthanasia cannot be justified on paternalistic grounds, however, for voluntary euthanasia is an act for which good reasons exist. Voluntary euthanasia occurs only when, to the best of medical knowledge, a person is suffering from an incurable and painful or extremely distressing condition. In these circumstances, one cannot say that to choose to die quickly is obviously irrational. The strength of the case for voluntary euthanasia lies in this combination of respect for the preferences, or autonomy, of those who decide for euthanasia, and in a clear rational basis of the decision itself.

That quote goes some way to addressing the concerns raised by Hon Col Holt. The bill provides legal clarity for practices that are already occurring. Every year, through the relief of pain and suffering, many people in Western Australia experience euthanasia and no legal action is taken. This bill provides a framework to protect those people who practise voluntary euthanasia. I draw members' attention to clause 5, "No obligation", which means that any unwilling ancillary staff, such as nurses, which Hon Brian Ellis mentioned, can opt out of any of these actions. There is an explicit clause stating that anyone who is at all concerned about it can opt out and there is no compulsion or obligation for that person to be involved.

Members have spoken about the importance of whether the public supports this legislation. It is important to me and that is one of the reasons I am supporting the bill. A study on euthanasia by Newspoll shows that 86 per cent of Western Australians are in favour of euthanasia laws and that 92 per cent support it in the regions. I seek leave to table that document.

Leave granted. [See paper 2531.]

Hon LYNN MacLAREN: Because I am always curious about how statistics are used and the important thing is what question was asked, not only how many people were asked, I will read the question asked by Newspoll —

The next question is of a sensitive nature but your honest answers are important to us. Thinking now about voluntary euthanasia. If a hopelessly ill patient, experiencing **un**relievable suffering, with absolutely **no** chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?

As we know, the answers to that question were overwhelmingly in the affirmative.

The bill will put in place a system with very sound safeguards. To make a request for the administration of euthanasia, a person must be a competent adult over 21 years of age and he or she must have been resident in Western Australia for three consecutive years. We talked about the state of mind of the patient. If a patient's motivation is driven by depression or anxiety, they are not eligible to seek voluntary euthanasia through this bill. An applicant must be fully assessed by two different medical practitioners on two separate occasions with 14 days in between. Hon Michael Mischin indicated that there was no cooling-off period. I suggest that that may have been erroneous. There is that 14-day period between one medical practitioner assessing a person and a second medical practitioner assessing a person. In other jurisdictions that can be as short as nine days. I think 14 days is a good cooling-off period.

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Hon Robin Chapple: Can I just correct you? Two medical doctors assess you, then there is 14 days and you are assessed again.

Hon LYNN MacLAREN: That is even better. In either case, there is a 14-day cooling-off period in between medical assessments.

Another reason I am supporting this bill is that the importance of palliative care remains, even with this bill. I note that many people who wrote to me to oppose the bill were strong advocates of a well-resourced palliative care system. I entirely support this. In fact, under this bill the applicant must be fully informed of all medical options, including palliative care. Palliative care will meet the needs of many more dying patients than voluntary euthanasia. There are, however, a number of degenerative illnesses that condemn an individual to a traumatic, humiliating death in which nothing can be done to relieve the suffering. It is for this group that voluntary euthanasia advocates compassionate law reform.

We also argue that the possibility of taking control in the late stages of a terminal illness will provide great comfort to the elderly as well as to the people with illnesses that are technically terminal but only fatal after very long periods. They will know well in advance that they have the capacity to take control if they need to, even though, statistically, we know from places with lawful voluntary euthanasia that the vast majority of those who would consider asking for voluntary euthanasia will end up dying without needing it. That is why I illustrated the evidence that we have from Oregon. Despite the best palliative care in the world, we know that 25 per cent of late-stage cancer patients experience moderate to severe suffering. Other diseases can cause equal or even more profound suffering. Palliative Care Australia, the Australian and New Zealand Society of Palliative Medicine and the Australian Medical Association have acknowledged that not all of their patients can be helped. Palliative care has strengthened in the jurisdictions in which voluntary euthanasia laws are in place. I note that situation particularly in Oregon, in the Netherlands and other jurisdictions. Let us not forget that due to the experience in the Netherlands, the neighbouring countries of Luxembourg and Belgium have also embraced laws of this nature.

The rights of people who do not choose to take up the option of voluntary euthanasia are still supported by this bill. I point again to clause 5 “No obligation” which states —

No person may be compelled to do or omit to do anything ...

We have provided safeguards for those who may want to take up the path. It does not affect those who choose not to take up the path. It is just an option for those few people who may wish to take it. It will be their own choice. I, myself, have noted that, at any time, a person can withdraw his or her request and say, “No; I have changed my mind; I want to keep going.”

Several speakers have listed what the bill does not do among the reasons they would oppose the legislation. In fact, some have gone to great length to describe what the bill does not do. For me, that is not a reason to oppose the bill. Let us look at what the bill does; let us look at what it can do. For those very few who would be eligible and those who would choose to go down this path, we can provide a stable and supportive structure to take that step. I agree with Hon Sue Ellery; she was the one who said, “How I die is just as important as how I live. It is right and proper that the state does not stand in my way. It is not right for the state to turn a blind eye and put family members at risk.” We are obligated to provide some protection. I cannot, in good conscience, deny people a right to face death on their own terms should they choose to; therefore, I support this bill.

HON KEN BASTON (Mining and Pastoral) [7.46 pm]: I rise tonight to say a few words about this bill. I guess the first question is: what is this bill about? The essence of it lies in the following words taken verbatim from Hon Robin Chapple’s website. I will read one paragraph —

The Bill establishes an administrative structure that can only be enacted by mentally competent adults who live in Western Australia. It will allow such a person, who is terminally ill and in pain and suffering, to make an application for the administration of euthanasia. That application must be assessed by 2 independent medical practitioners, who will assess the application on the basis of strict and lengthy criteria which is set out in the legislation. If that criteria is passed, the terminally ill patient must then restate his or her wish for a “good death” before euthanasia may be administered. Again, euthanasia may only be administered in accordance with the strict and lengthy requirements set out in the Bill

The bill is not, in my view, about euthanasia as it is seen by many of the people who corresponded with my office. They certainly have a totally different idea of it. This bill, as it clearly states, is to set up an administrative framework that will allow, in blunt terms, the administering by a medical practitioner of a lethal injection at the request of a patient. The provisions of the bill allow this to be administered to a particular set of persons who

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meet a series of very defined criteria. The bill then, is not about the rights and wrongs of euthanasia, but pre-empted that debate and says that euthanasia is right in the circumstances prescribed in the bill. The bill is about putting people to sleep, to use a common euphemism, and not just about dying, but about the manner of dying.

Much is made of the Greek roots of the words “eu” and “thanatos”, and the translation of these words by proponents of euthanasia as a meaning of good death. However, there are other meanings of good death; for example, the ancient Greeks and other warriors at the time saw a good death as one that occurred in battle. Dying for a good cause was also seen as a good death. In later times a good death was seen as meaning a welcome, natural and gentle way to depart from life. Possibly, for most people, this is what it was like at the end of their lives in those times when people died at a younger age before the advances in medical science and technology that keep us all alive for longer. The meaning now is quite removed from perhaps this idealistic view of death. The meaning now is that it is a deliberative act of hastening death; and it should be seen as such.

I have spent some time reading this bill, and, as far as it goes, it provides some answers to the objections that have been raised about the practice, and the possible abuse, of legalising euthanasia. It also raises some significant questions that I think are critical and relevant to the end-of-life scenarios that confront us today in Western Australia.

I turn now to the answers in the bill. The bill clearly provides that the person who is seeking euthanasia is the only person who can request it. The bill also makes explicit the conditions and witness arrangements, which will exclude from any involvement in the request any person who may gain any financial benefit from the death of the person. These provisions have the aim of ruling out family and others who may get an early inheritance windfall as a result of euthanasia being made available. It clearly sets out the conditions under which euthanasia can be requested. These provisions attempt to rule out the scenario of a person wanting to relieve the family of the burden of caring for a sick person. Unfortunately, what the bill does not do is ensure that no family pressures, either overt or covert, are put on a person with a terminal illness to seek euthanasia. It clearly indicates the type of illness that needs to be present before the request will be granted. The illness has to be terminal, and there has to be considerable pain and suffering associated with the illness. This will rule out euthanasia being available just because a person is tired of living or has a chronic, but not terminal, illness, so that it cannot be used as a suicide-on-demand arrangement.

In addition to these provisions, persons who request euthanasia must be of sound mind and able to communicate their intentions. This will rule out people with Alzheimer’s disease, people with a mental illness who have a terminal illness, and people who have multiple and significant disabilities who are unable to communicate their intentions.

There will be a cooling-off period of some 14 days, as I think Hon Robin Chapple mentioned a while ago, between the initial request and the final request, following which euthanasia can be carried out.

The process will involve three doctors: one who agrees to administer the lethal injection, one who confirms the request, and, at the end, an observing doctor who has been independent of the process. Thus, provided that the provisions in the bill are scrupulously followed, the intent of the bill to provide immunity from criminal or civil liability for persons involved in the process will be successful. That will make the act of euthanasia a lawful act in the circumstances set out in the bill. This is where the bill becomes contentious. I draw a distinction between a deliberative act to administer what is known to be a legal injection, and the administration of a painkilling drug in the course of good palliative care. If, as alleged, practices of deliberate euthanasia are being carried out under the guise of the administration of painkilling drugs, and we hear no outcry, I would ask: why do we need this bill?

I alluded earlier in my remarks to the questions that are raised by the bill. Some of those questions are practical; others are more philosophical. I will take a few moments to address what I see as practical questions. The first relates to the words “no financial advantage to be gained”. I link this with the words, “a witness cannot be a relative”. There is as far as I can see nothing, apart from a statement in the bill, that safeguards against a relative, near or close, from gaining a financial advantage. For example, a cousin can be witness. Who is to say that there has been any extensive family discussion, including with the person who is seeking the euthanasia, before the application was even made?

The second question, and perhaps the major practical question, is one that has a particular significance in the Mining and Pastoral Region. That is, of course, my electorate. I refer to the availability of medical practitioners in remote and regional Western Australia. There are a number of aspects to this, one of which is the difficulty of attracting and retaining doctors in some areas of the state. Another is the very practical aspect of finding a doctor in the limited population of doctors who would be willing to take part in the euthanasia process. This has a direct

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relevance to a third and major obstacle that the Voluntary Euthanasia Bill 2010 faces, which is that the president of the WA branch of the Australian Medical Association, Dr David Mountain, said on the ABC's *Morning* program yesterday that the AMA does not support the idea of doctors administering a lethal injection. The role of a medical practitioner is seen as one of easing pain through palliative measures, not that of easing pain through an injection that leads to death. Even if the bill is passed, people in the regions face considerable obstacles, given that in most regions we are more likely to have doctors who are locums or are only in the community for a short time.

My next question about the bill relates to the large number of submissions I have received from families who sit on both sides of the debate. Advocates of voluntary euthanasia contend that if a person is suffering from a terminal illness and is unlikely to benefit from the discovery of a cure for that illness during what remains of his life, and is, as a direct result of the illness, suffering intolerable pain or only has available a life that is unacceptably burdensome, has an enduring, voluntary and competent wish to die, or has, prior to losing the competence to do so, expressed a wish to die, then there should be legal and medical provisions to enable him to be allowed to die or assisted to die.

But in this debate there is a further question: what happens for people who do not meet these conditions? I read the letters and emails I have received, and I am sure members have received many, and most of them are from people who are pro-euthanasia. They relate situations whereby a much-loved parent or grandparent has advanced Alzheimer's disease. There have been similar stories from people and families who have degenerative illnesses and who sought what they saw as a relief from the inevitable progress of disease through a euthanasia process. The question comes from families with members who have mental conditions and are not of sound mind but who meet the other conditions of the bill in terms of prognosis and pain.

What hope is there for the persons who do not meet the very strict criteria of this bill? There are answers that do not rely on euthanasia. One answer may lie in the use of the consent to medical treatment legislation—living wills—that I supported when it was before this Parliament in 2007. That legislation allowed people to make an advanced preparation for the sorts of medical interventions that they would like in the event that they are struck with severe and possibly fatal conditions later in their lives. This could be thought of as passive or voluntary euthanasia, in which life-sustaining or life-prolonging measures are withdrawn or withheld, which was seen as acceptable.

Another answer lies in the use and availability of palliative care, and an increased awareness of what it offers. I am grateful to Hon Liz Behjat for reading into *Hansard* the definition of palliative care last night. If that were more widely known, I believe that it would dispel many misunderstandings of what is meant by palliative care. There seems to be the impression that palliative care exists to prolong life or perhaps unnecessarily shorten it; that is not the case. Palliative care, it seems to me, aims to be about assisting the person to enjoy a quality of life as the illness progresses; it is not about prolonging suffering through unnecessary, futile interventions. It is about easing pain and suffering. It is an honest process involving the patient, the family, the doctors and the nurses.

In conclusion, I refer back to my introductory remarks when I said that this bill is not about the rights and wrongs of euthanasia. The bill says that euthanasia is acceptable but only under the particular set of circumstances set out in the bill. It does not provide answers to those families who have circumstances that are outside the parameters of the bill. The community debate about euthanasia is not going to go away, as some other members said yesterday. The answers to the debate are not found in the polls, which simplify very complex, medical, ethical, moral and religious viewpoints into approval or disapproval answers. I do not know if we are ever going to be able to say that the act of euthanasia is right or wrong, because the circumstances in which people believe it to be right or wrong are so different and varied. I do know that there are circumstances when I believe that euthanasia is wrong. These would include when pressure has been put on people who are perceived to be a burden to their family to take the euthanasia option; when it involves people who are not able to make the decisions for themselves; and, when someone is going to profit from the act. As a society we do our utmost to ensure that the rules, regulations and laws that we live by are not discriminatory in nature. Whilst there is good intent in the bill, I consider that this is a discriminatory bill. It is also a bill that should not be here until there has been a much lengthier debate and wider community agreement on whether euthanasia as a concept is something that we want to embrace. In the meantime, if we want to use the word "euthanasia" to describe the event of death, we should go back to the original meaning from the Greeks and provide a good death through palliative intervention, not a lethal injection.

I return to my earlier words and say that palliative care does not aim to prolong life; rather, the desire of providing palliative care is to assist a person to enjoy a quality of life as an illness progresses. It is not about prolonging the suffering through unnecessary futile intervention. It is about easing pain and suffering and is an

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honest process involving patient, the family and friends. It is about providing a good and peaceful end of to someone's life, not providing an abrupt end that would be brought about by a deliberate act. I therefore cannot support the bill before the house.

HON ED DERMER (North Metropolitan) [8.02 pm]: I rise to oppose the Voluntary Euthanasia Bill. In explaining why I am opposing the bill I am going to endeavour to address each of the five reasons put forward by Hon Robin Chapple in proposing the bill. Hon Robin Chapple referred to his mother's misfortune. I am very sorry that was the case. I can understand that when we see someone suffering, there is a reaction and we wish to do whatever we can to alleviate the suffering. I think that all of us are very lucky to be alive now, because even in a relatively short time in the past doctors were less capable of assisting us. I do not know when Hon Robin Chapple's mother died, but I think it was some time ago. From what I have learnt, the art of caring for people under those difficult circumstances has improved enormously since then. I believe that the first reason, based on his mother's misfortune, is one that is now in a blessed way becoming more distant. It is a reason that was more relevant in the more distant past. As palliative and other medical care improves, I think the stories that we have heard from people, who often talk about parents or others of an older generation, will become more distant. I was surprised to hear Hon Alison Xamon talk about her grandfather's more recent experience as being a very difficult one, because the information that I have received from elsewhere indicates that in more recent years palliative care has advanced to the extent that, although the experiences of others, perhaps 10 or 15 years ago, might have been terrifying, such experiences today are much less terrifying with the advance of palliative care. Palliative care is of course not perfect, but fortunately, as in every field of medicine, advances will continue.

I was very pleased to have the opportunity to listen to Dr Andrew Dean, who is the chief of oncology at St John of God hospital in Subiaco. He is a man who is actually out there providing palliative care, and he is full of confidence in the work that he does and the support he is able to provide people in difficult circumstances. He certainly opposes voluntary euthanasia. He explains—as Hon Liz Behjat did very clearly last night—that there is a lot more to palliative care than just pain relief. It actually involves support of the whole person to encourage that person to feel that his life is worthwhile to the very end of his life. I imagine that in that type of environment, where others are suffering in a similar way, with family coming to visit, a spirit of community can develop in the hospice where palliative care is provided; other palliative care is obviously also available at home.

Talking to Dr Dean was quite an inspiration, and he made it clear that much can be achieved in palliative care. I fear this was, sadly, perhaps not available to Hon Robin Chapple's mother at the time she passed away, but it is a continually advancing field. I was heartened to meet someone whose profession it is to help people in need being so positive about what he is able to achieve and what the people in need experience. There was no doubt that his firm view was that he was opposed to the bill before the house.

It is essential that we appropriately resource palliative care, aged care and every other aspect of health care. Interestingly, although I totally oppose this bill, if the legacy of this debate as predicted by Hon Alison Xamon actually comes true—that is, drawing the government's attention to the need to further resource palliative care—it will be a very positive legacy.

I have been challenged by people who have asked me, "You're a member of Parliament; are you sure that palliative care services in Western Australia are adequate?" That led me to put a couple of questions on notice to the Minister for Health, and I could see that progress was occurring; I would like to see more progress. I took advantage of the opportunity to talk to Dr Dean as someone who is in the field providing care. He was very positive about the availability of palliative care in this state, and I felt better for having heard him say that. He suggested that in Western Australia, particularly in the public sector, there is a very high quality of palliative care available. It puzzles me when I try to reconcile that with Hon Alison Xamon's description of her grandfather's experience. One member—I think it was Hon Ken Baston—talked about the importance of people being aware of the availability of quality palliative care. That may have been the problem for Hon Alison Xamon's grandfather, if he went through a particularly traumatic experience; I am very sorry to learn that he did. Lack of knowledge about the availability of service may well be an explanation for why we are hearing, on one hand, that the quality of palliative care is there and, on the other hand, that it is not available. That inconsistency remains a mystery, but one explanation may be that Hon Alison Xamon's family was unaware of the availability of quality palliative care.

Palliative care is clearly not perfect, but it continues to improve. My meeting with Dr Dean was very heartening and very encouraging, and I am sure he would happily make himself available to any member of the house who would like to talk to him about his work. We would all be wise to learn more about his work, and having members of the Legislative Council who are more informed on that issue will be part of the very important work that needs to be done to advance the progress of palliative care. Hon Jon Ford today also emphasised the need to enhance that service, and I was very pleased to hear his comments this afternoon.

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The second reason put forward by Hon Robin Chapple was compassion. In many ways, I have really enjoyed this debate; I have met some very interesting people and had some interesting discussions with colleagues. In fact, the initial one was probably with Hon Robin Chapple himself when we discussed a draft of the bill. I have had fascinating exchanges of correspondence with members of the public. However, there has been one part of this debate that I have not enjoyed at all; that is, hearing all the terrible reports of the suffering that occurs in people's lives. That really gets to me. I am probably not a very tough individual because when I hear about the horrific things that happen, my first thought is, "Thank God that hasn't happened to me or a member of my family." My father died of Alzheimer's disease and that was an unpleasant situation to go through, so I have had some personal experience. However, some of the things that happen to people are absolutely appalling and it makes me wonder about the nature of the universe where these things occur. Our first reaction is to do whatever we can to help. If these people are saying, "We want voluntary euthanasia", it is very hard to say, "No". However, I believe that we must say no because there are other reasons, which I will endeavour to explain this evening, why we must say no, and it is really hard. I hope that we can find every other means in which to alleviate suffering where it occurs. There are really heart-wrenching accounts of what people go through, and it is a shocking thing. I can understand a first desperate impulse, perhaps like Hon Jon Ford's reference to that terrible back pain that he was going through, to say, "End it all", but it is not the best answer and it has consequences that I think are very dangerous for our community.

The other reason put forward by Hon Robin Chapple to support this bill is this notion of autonomy and choice. I have heard it from many speakers so far in the debate who said, "If someone chooses to want to have voluntary euthanasia, why should we stand in the way of their choice? Why should the state stand in the way of their choice?" The word "state" often reminds me of references made to that in the Soviet Union and it gives me a bit of a chill—why should the state stop me choosing this? I do not want to tell people no and I do not want to take away anyone's autonomy. But if the price of that choice, the price of that autonomy, is to risk exposing other people to pressure to accept voluntary euthanasia in a way that I think Hon Ken Baston described very well, then that price is too high. Therefore, I will simply say it in a sentence. We would like people to have choice and autonomy, but I will vote for them not to have autonomy and the choice to choose voluntary euthanasia, not because I bear any ill will for the people who want it, but because I fear the legality of voluntary euthanasia will expose other people to pressure to accept it. I have to weigh one against the other, and in making this decision I came down on the side that as much as we might want to give people autonomy and choice, it is not acceptable to expose others to pressure to accept euthanasia. As much as I think Hon Robin Chapple has with the most honest of intent tried to develop a structure to protect a potential applicant for voluntary euthanasia, I simply do not think it is possible, Robin, to protect them and that is why I oppose the bill.

As a Parliament, we must debate and deliberate to consider all the implications. One of the strengths of this type of debate is that most members of Parliament will endeavour to share their thoughts with their colleagues in the chamber. Our first duty, of course, is to consider the bill as it is and the point has been made, I think by Hon Lynn MacLaren, that members have been discussing points other than what is in the bill. I will do the same right now, Hon Lynn MacLaren, because I think that once we accept voluntary euthanasia, even in its most restricted form, we cross the threshold and there is very likely to be future legislative development to broaden the legislation to encompass more circumstances for voluntary euthanasia and that would further expose more people to the risk of being pressured to accept euthanasia. It is important that we make it clear when we are talking about the bill and when we are talking about the progression of euthanasia that could follow from crossing the threshold, which we would do if we endorse this bill, to distinguish between the two, and I will try to talk about both. If we support this bill and it passes through both houses and receives royal assent, the threshold is that it would make legal the deliberate taking of human life, as detailed in the bill. That is an enormous threshold. That step in itself would, with a very high probability, lead to further legislation to further extend euthanasia. That is one of the reasons I am opposing the bill.

There is a document that I found very helpful and I would be delighted to lend it to members with my few annotations, if they like. Alternatively, I recommend that members get a copy of it from our very helpful friends in the Parliamentary Library who provided me with my copy. If I had unlimited time I would be tempted—but I will not—to inflict on members a reading of all of the content, as it is very worthy of consideration. The document is a report, entitled "Report of the Select Committee on Medical Ethics": House of Lords: Session 1993–94", and is obviously a report of the House of Lords in the United Kingdom. It has hundreds of paragraphs, and I have selected two to share with the house, which I think are the most important and I will take the opportunity to read them out. Paragraph 238 states —

One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia.

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That is, basically the conclusion not to support the adoption of voluntary euthanasia. It continues —

Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address. Fear of what some witnesses referred to as a “slippery slope” could in itself be damaging.

I will hopefully have time later to refer to a Dutch paper that I examined that makes reference to the “slippery slope”. The very next paragraph is the other one from the House of Lords’ report that I want to share with members. Paragraph 239 reads —

We are also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.

It is a very well balanced report. That committee of the House of Lords went to a great deal of trouble to make sure that it considered every point of view and sought witnesses who were experienced in the matters of later life. I very strongly recommend the report to the attention of members, but I am hoping that those two paragraphs will give a flavour of the conclusions to which the committee came.

I have every confidence in the honesty and integrity of Hon Robin Chapple’s intentions. I just sadly think that Robin is very wrong. He may hold a similar view in respect of me. I admire persistence. A couple of members of this chamber with whom I rarely agree and whose persistence I admire are the honourable Leader of the House and Hon Robin Chapple. But that is distracting, so I will not go too much further on that.

When Hon Nick Goiran quoted Hon Robin Chapple’s comments in the West Australian Voluntary Euthanasia Society’s magazine and said that Robin was putting forward a more restrictive bill while at the same time supporting a less restrictive bill, I reckon that is perfectly and entirely consistent. I can understand that. Hon Robin Chapple might want to achieve something else, but he reckons he will get this bill through so he will put it forward. I think that is what is happening, but Hon Robin Chapple will have the opportunity to comment on that later. I reckon the very fact that Hon Robin Chapple is talking about a wider bill is an indication that it is very important that we discuss not only the bill before us, but also the general principle of voluntary euthanasia, as it could assume a wider form, and I think that crossing the threshold of passing this bill would encourage further legislation in the future. I have certainly seen references from the Voluntary Euthanasia Society and in some letters from people writing to support the bill, which suggest this is very much a first step, and I am frightened by what they might consider.

We are talking about Western Australia. We are talking about our bill. We are talking about the Western Australian Parliament. However, it is instructive to look at another jurisdiction where voluntary euthanasia has been in place for some time. I am not necessarily saying that if voluntary euthanasia were to become entrenched in Western Australia, it would develop in the same way, but it is instructive to show how it might develop. I read a paper called “Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?” authored by Judith A.C. Rietjens, Paul J. van der Maas, Bregje D. Onwuteaka-Philipsen, Johannes J.M. van Delden and Agnes van der Heide. I apologise for my poor Dutch pronunciation. This was published online on 28 July 2009, and the abstract is there. I am looking at the clock and wondering if I have time to share the abstract with members. The abstract reads —

Two decades of research on euthanasia in the Netherlands have resulted into clear insights in the frequency and characteristics of euthanasia and other medical end-of-life decisions in the Netherlands. These empirical studies have contributed to the quality of the public debate, and to the regulating and public control of euthanasia and physician-assisted suicide. No slippery slope seems to have occurred.

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It interesting that that same term came up in the House of Lords' report. They are assuring the readers of this paper that no "slippery slope" has occurred. To continue —

Physicians seem to adhere to the criteria for due care in the large majority of cases.

That is an interesting reference to "large majority of cases" —

Further, it has been shown that the majority of physicians think that the euthanasia Act has improved their legal certainty and contributes to the carefulness of life-terminating acts.

That is interesting as it would support Hon Robin Chapple's argument. I do not believe that is the view shared by doctors here—certainly not the ones I have spoken to, and I think the Australian Medical Association's very clear view demonstrates the thoughts of doctors. I do not think I have seen anybody or any institution that more fiercely defends the interests of its members than the AMA. The AMA would be a beacon and an example to the Construction, Forestry, Mining and Energy Union, I would imagine, in how to fiercely defend the interests of its members. I would imagine its view on this bill would be the best available objective indication of the view of Australian doctors. But, according to this paper, doctors in Holland see things differently. To continue —

In 2005, eighty percent of the euthanasia cases were reported to the review committees.

The inverse of that is that 20 per cent were not, obviously! It is a little like those advertisements on food products: this is 97 per cent fat free. If we were told it was three per cent fat, we might be less inclined to buy it—I might be tempted! It is just a very interesting way of putting it to say that 80 per cent of euthanasia cases were reported, and obviously the corollary of that is that 20 per cent were not. The abstract of the article goes on —

Thus, the transparency envisaged by the Act still does not extend to all cases. Unreported cases almost all involve the use of opioids, and are not considered to be euthanasia by physicians.

It does not explain what they are considered to be. It may do in the body of the paper; I have just read the abstract tonight. I did read the full paper at an earlier time. To continue —

More education and debate is needed to disentangle in these situations which acts should be regarded as euthanasia and which should not. Medical end-of-life decision-making is a crucial part of end-of-life care. It should therefore be given continuous attention in health care policy and medical training. Systematic periodic research is crucial for enhancing our understanding of end-of-life care in modern medicine, in which the pursuit of a good quality of dying is nowadays widely recognized as an important goal, in addition to the traditional goals such as curing diseases and prolonging life.

That all sounds very cheery and normal, and it frightens the hell out of me. It has become quite normal and clear that, as one of the three roles of doctors in Holland, euthanasia is normal alongside curing and prolonging life.

The paper includes an interesting table of euthanasia figures. Table 1 outlines the frequencies of euthanasia and other end-of-life practices in the Netherlands in 1990, 1995, 2001 and 2005. It lists the figures for euthanasia, assisted suicide, ending of life without an explicit patient request, intensified alleviation of symptoms, and forgoing life-prolonging treatment. Interestingly, like Hon Ken Baston, I was happy to support the living wills legislation after amendments that I moved were accepted, sufficient to satisfy me that that legislation was not euthanasia in another guise. And it is not; it gives people options. It was an appropriate bill to support; this bill is not. According to the table in this Dutch paper, which refers to the absence of a slippery slope, ending life without an explicit patient request—I am happy to acknowledge it is a small percentage, and I am happy to provide this paper to anyone who might want to look at it—has clearly been entrenched as normal in Holland since 1990. It might be an appropriate way of life for some. I think Western Australia is better not evolving into something like the kingdom of the Netherlands in this respect.

I will try to move along as quickly as I can. I will get back to the bill as it is. This concept of voluntary euthanasia, and how it is likely to evolve, is demonstrated as a bit of a guide to what might happen by this liberal democratic country, which we also aspire to be, of the kingdom of the Netherlands. The best way to stop widespread voluntary euthanasia evolving is to oppose this bill, and that is why I am doing so.

One of the things that I am very proud of as a member of the Australian Labor Party is Medicare, and Medibank that preceded it. It is important that every Australian in our country can get a decent health service. I would like money to be no object in achieving that. I am worried because that is going to become less and less attainable for a number of reasons. Reference has been made today by other speakers to the increasing age of our population. Frailness of health does not necessarily come with age, but, as a general population tendency, it does for more

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people. More elderly people are going to have frail health as a proportion of the population than will a cohort of younger people.

The other terrific news that also entails a problem is the progress of medical care. More can be done now to sustain our lives and our quality of life than could be done before. The reality of this, as was made very clear by Hon Jon Ford this afternoon, is that it costs. There are people in Australia who die because they cannot afford medications which are required perhaps for a relatively short period but which might cost tens of thousands of dollars and because taxpayers, through the pharmaceutical benefits scheme, decide that they cannot afford to provide these medications. That is my understanding of what Hon Jon Ford said this afternoon. Hon Jon Ford is nodding sagely, so I take that as an affirmative. This is going to become ever more the case. As much as universal health care and everything that everyone might need should be provided to everybody, and I would like to see a helluva lot more taxpayers' money spent to achieve that objective—the good thing about this debate is that members get an opportunity to remind colleagues, including cabinet members opposite, of the importance of doing that—the real danger is that, as a larger proportion of our population gets older and as more can be done, there will be a growing gap between what is available to people who have money to afford it and what is not available for those who do not.

I went through 13 difficult days in early 2008 when I waited on tests to tell me what the likelihood was of my having a terminal illness. Luckily, at the end of the 13 days the news was good, and since then it has got better. A friend of mine had headaches that his general practitioner said were consistent with brain tumours and he waited for a number of weeks to have the basic test to make sure that that was not the case. I cannot remember how many weeks it was, but it was not 13 days. To the best of my memory, it was six or seven weeks. I reckon that with the growing demand for health care, the growing expense of health care and the growing possibilities of health care, the gap between what the rich and poor can afford is likely to increase. I hope that does not happen. I hope that governments and taxpayers across the country are prepared to spend to narrow that gap, but I fear that that may not be the case. I fear also that a wealthier person would be better able to resist the pressure of accepting voluntary euthanasia than a less wealthy person. Why? If the disease is not terminal originally, it might become terminal if the person does not get the appropriate health care. Finding out about a brain tumour sooner rather than later is likelier to give a person a prognosis of living a longer life. It is very realistic to anticipate the possibility, perhaps in the not too distant future, of a person being required to potentially spend hundreds of thousands of dollars on his health or to accept voluntary euthanasia. I do not need to be reminded that this bill is about people who have a terminal illness. I am probably projecting into the future the type of legislation that will follow once the threshold of doctors terminating the life of a patient in the face of a disease is accepted if this bill is enacted. A very frightening scenario is a future in which the rich have access to the finest modern medical life-sustaining technology and voluntary euthanasia is an expedient available to the poor.

I have already referred to the comments about the pharmaceutical benefits scheme. I never had either the privilege or the burden of sitting in cabinet. I have obviously spoken to many people who have. I can imagine that members of cabinet judge pressures and try to match the demands with the resources. Demands are always more infinite than resources. It would be a very brave government, which I would be very keen to commend, that introduced a large new tax to bridge the gap between people who can afford to pay for their own medical care and those who cannot, given the increasingly ageing population and the increasing medical possibilities. That sort of expenditure would be needed to remove the dilemma confronting a person choosing between expensive treatment and voluntary euthanasia. Treatment could require spending money that the patient took a lifetime to earn. If the person does not have that sort of money, the choice that we have been talking about so much tonight would become ever more diminished and the pressure would mount for the patient to accept voluntary euthanasia. I do not believe that it is possible to protect people from the pressure to accept euthanasia in the event that voluntary euthanasia becomes legal, and that is why I am opposed to the bill.

The fourth reason put forward by Hon Robin Chapple was legal clarity. Hon Robin Chapple, in his second reading speech, said —

Euthanasia is a frequent and, it seems, fairly uncontroversial result of good palliative care. It happens when a doctor acts out of compassion and quietly administers what he or she thinks may be slightly too many sedatives or painkillers. Death may not necessarily be intended in this instance, but it is an outcome that is possible and borders on an anticipated outcome.

That is an interesting statement. I do not think the law lacks clarity. With the utmost respect, Hon Robin Chapple, I believe there is a lack of clarity in that paragraph and I will try to clarify it now for members. Euthanasia is a deliberate action that has a purpose of ending life. If euthanasia occurs today, it is illegal. I imagine that is why Hon Robin Chapple put this bill forward. Administration of pain relief medication, which may have the unintended consequences of shortening life, is not euthanasia. Such administration of medication is

Extract from *Hansard*

[COUNCIL - Wednesday, 22 September 2010]

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legal. It is interesting that reference was made to morphine. After listening to Dr Dean, I learnt there are far more refined drugs available today for relieving pain than morphine. This is part of this ever-growing advance in palliative care. It would seem that other drugs that Dr Dean talked about do not have that consequence. I think the whole thing is about the intent and purpose. If the intent is to end a life, it is euthanasia. If the intent is to relieve pain, it is to relieve pain. If it has a consequence of shortening a life, that is an unintended consequence. That is legal now, and I think that is appropriate. If the pain and suffering is sufficient that it requires medication to relieve the pain, then so it does. I think the existing legal situation is far clearer than what is entailed in the bill. I imagine that illegal euthanasia may occur today because most illegal things occur in our society and that is not a reason for changing the law. Our job is to choose the laws that we think are best for our state. I do not think any of us are delusional enough to think that all of our laws get obeyed 100 per cent of the time.

In his second reading speech, Hon Robin Chapple also said that the current law affords inadequate protection for doctors. I am not a legal expert. As I said before, I think the AMA is fiercer than the CFMEU when it comes to protecting the interests of its members. If the AMA does not like it, I imagine it would be looking after the aspirations, concerns and needs of its members. Hon Col Holt raised that very point about euthanasia, saying, "I don't need to kill myself. I'm incapable of killing myself. I want somebody else to kill me." The difficulty there is that a person is handing it on to someone else. That is an issue. The paper that I read earlier suggested that doctors in Holland have got used to this. I do not know whether that is true but that is what the paper reported. Elsewhere in either that paper or another one it referred to doctors in Holland who had administered voluntary euthanasia once and then refused to do it again. Hon Ljiljana Ravlich made reference to Dr Nitschke having uncomfortable feelings after administering euthanasia. It did not stop him doing it again or advocating it. Not every doctor would be the same. Not every doctor's opinion would be the same as that of the AMA. In a private conversation with Hon Ken Baston today, he pointed out—he also raised it in his speech—that doctors in rural areas are fewer and farther between and because of the pressure on people to accept voluntary euthanasia for a range of health, financial or other reasons, the pressure might be on them to administer it. I think there would be lots of difficulties being a doctor. I applied to do medicine and fell so far short of the requirements that it was almost farcical. With the sorts of pressures there are on doctors, it may have been a good thing.

I appreciate the work that Hon Robin Chapple has done to ensure that this process involves three doctors and all these different stages and that the people in that process are prevented from being financial beneficiaries on someone's death. I think the process would be designed to ensure that those people do not pressure a potential applicant for voluntary euthanasia. I think Hon Robin Chapple would agree with me that none of that prevents someone else from pressuring a person to accept voluntary euthanasia. We hope that families would be very supportive but if there were questions of assets and whether they should be spent on health care or made available through a will after someone passed away, we would hope and like to think that all families would be supportive of the best interests of the person concerned. After talking to the president of the WA Voluntary Euthanasia Society about his professional experience in aged care, he mentioned that there are families he would rather not have met.

I fear for the people who might be under pressure to accept voluntary euthanasia in the event it were to become legal. The most pernicious pressure on someone to accept voluntary euthanasia would probably come from themselves, not wanting to be a burden. If their life experience around them and circumstances were not as positive as those referred to in the establishments Dr Dean was telling me about, maybe they would feel that life was not worth living; that they were a nuisance and that they would be better off giving their wealth to someone else, if they were lucky enough to have any, rather than spending it on their own care. All this is really grim when we start to imagine the feelings of the person who is facing that pressure. That pressure will be enormously enhanced by the legalisation of voluntary euthanasia.

One clause of the bill that particularly disturbs me is the immunity clause 15(1). I am concerned that I am running out of time. It reads —

An applicant, the applicant's medical practitioner, the second assessing medical practitioner, the observing medical practitioner and any other person who does or omits to do any thing required or permitted under this Act:

- (a) does not incur any criminal or civil liability; and
- (b) is not liable to any disciplinary proceeding; and
- (c) is not liable to any other negative action from any relevant professional bodies, if what the person did, or omitted to do, in relation to the relevant applicant, was done in accordance with this Act.

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That sounds to me like a totally circular argument. I sought advice from a source that I, by convention, am not allowed to name in the chamber. That adviser told me that he does not believe this is anywhere near a normal immunity clause. I think Western Australia is blessed by not having a Parliament comprising only lawyers, but I think there is a certain utility in having a certain number of them in the chamber. I would like the lawyers in the chamber to have a good look at that and, hopefully, reassure me that it does not mean that anyone who breaches any part of the requirements of the bill would be immune.

Hon Robin Chapple: Immunity is authorised.

Hon ED DERMER: Yes. The explanatory notes state that section 15(1) affords immunity from criminal or civil liability and other negative conduct to any person who does something required or permitted under the act so long as what that person did was done in accordance with the act. From the explanatory memorandum it sounds as though there is no liability if we do what we are supposed to do according to the act. The immunity in the act says nothing clear at all. It states in part —

... if what the person did, or omitted to do, in relation to the relevant applicant, was done in accordance with this Act.

I am not legally trained; I am a scientist by training and a historian by interest. I will leave that to Hon Robin Chapple to address in his response. It sounds suspiciously to me like something that would be included in a bill in the hope it would provide immunity from anything that might occur in the course of following the proceedings specified in the bill. I have four minutes; that might be sufficient to answer the fifth reason put forward by Hon Robin Chapple on the evidence of public demand. I am trying to imagine someone from an opinion poll who would ring up someone and allow a 45-minute discussion, access to the very good people in the parliamentary library to fully research the issues and a free exchange of all the conflicting, competing and different thoughts in the chamber. That does not happen with opinion polls; we are rung up when we are trying to prepare breakfast or something and we quickly say something to get the other person off the phone. Opinion polls can be amazing. I was amazed at the last federal election how accurate they were, based on the very small samples involved. I am very pleased that what has evolved in the United Kingdom and what we have inherited as a Westminster parliamentary system is not government by opinion poll. Parliaments have an opportunity to debate, to deliberate and to consider. A matter of this gravity—a matter literally of life and death—needs the most thorough consideration of the Parliament, thorough consideration of the bill before us now and thorough consideration of the implications that would follow from the enactment of a bill that crosses that threshold of accepting the taking of life in the name of medical care. So I do not feel at all instructed by opinion polls as to the decision that I have to make, as a duty, for the best interests of the community of Western Australia; and that is what motivates me.

I wish to thank the many correspondents who have written to me, and also the people who have telephoned me or raised matters in other ways. There were three particular people who, when I wrote back to them, wrote back to me again, and I wrote back to them, and they wrote back to me again, and so I sent off a third letter. It was terrific. Every time I wrote one of those letters, it sent me back to the Parliamentary Library to study some more papers. These characters were really—I do not know whether “feisty” is the right word—strong characters. They totally disagreed with me, they were not giving up, and they really took me on. I really appreciated that. I appreciated all the correspondence that I received, but I appreciated the correspondence from these three people in particular. That is terrific. That takes me back, again, to the strength of our Westminster system of government, and to the active citizenship which we do not see in everybody but which is certainly there as an option for people to take up, and that is a wonderful thing.

Some people told me, whether on the phone or by letter, that there was no way anyone would ever pressure them to accept voluntary euthanasia. I reckon that for these feisty, strong characters, who were prepared to take me on and have an interesting tussle with me, that is absolutely true. I imagine they will be strong characters for a good 10 years after they get their telegram from Her Majesty to say they have reached the age of 100. I imagine that that feistiness will keep them going for a long time, and good luck to them. They will probably be keen to vote against my re-election for a long time as well, based on our differences in view, and that is fine; that is what it is all about. They are not the people I am worried about. Such strong, feisty individuals are not the people that I am most concerned will be pressured to accept euthanasia in the event that it becomes legal. It is the unsure; it is the lonely; it is the people who wonder about how widely they are appreciated—widely is not important; how intensely they are appreciated—by the small number of people around them. They are the ones who will be most vulnerable if we are unwise enough to enact the bill before us. On that basis, I ask members to oppose the bill.

HON KEN TRAVERS (North Metropolitan) [8.47 pm]: There are many speakers who have gone before me in this debate on the Voluntary Euthanasia bill 2010 who have probably made far more eloquent speeches than I will make tonight in putting on the record much of the material that I have relied upon to reach my decision on

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this bill. But I do think it is incumbent upon all of us, on a bill such as this, to put on the record for our electors our position and how we have arrived at our position. For those electors in the North Metropolitan Region, it is probably fortuitous that they can read one speech in *Hansard* and immediately follow on with another speech from a Labor member, so that will make it easy for them.

This is an interesting bill. I understand the difficulty that I think all of us have had, some of us in different ways, in dealing with the intellectual concepts that underpin this bill, and about our support, or otherwise, for it. I suspect that all of us have had to think deeply about this piece of legislation. At a very superficial level, it would be easy for me to say that the concept of euthanasia is one that I support. I recognise also that the detail of a piece of legislation such as this is very important. As I have worked through this piece of legislation, I have wrestled with the legislation at various stages and there have been many times when I have considered whether I should go to Hon Robin Chapple, as a matter of courtesy, and say, "If you're counting on my support, don't."

I have also taken the time to consider the correspondence that I have received in my office. On a matter such as this, it is not the quantity of correspondence that we receive on one view or another that is important. We have all had experiences in the past when we have had a referendum and we have received a lot of correspondence prior to that referendum about the various views, and ultimately the view that prevailed in that referendum was different from the weight of the correspondence that we received in our office. But I have looked at the arguments that have been mounted, considered them and given weight to them. To those people who wrote to me, I appreciate that and I assure them that whether I end up agreeing with them or not, I have given consideration to the arguments they put to me.

It has been interesting that much of —

Hon Max Trenorden: You're sounding like Oakeshott!

Hon KEN TRAVERS: Sorry?

Hon Max Trenorden: You're sounding like Oakeshott!

Hon KEN TRAVERS: I was going to mention—or maybe it is just my impression—that this debate has been conducted without much interjection, to date!

Hon Max Trenorden: I like to break the rules!

Hon KEN TRAVERS: Or maybe I just encourage it from Hon Max Trenorden!

Much of the debate on the Voluntary Euthanasia Bill 2010 to date has jumped over the policy and got into the detail of the bill. As we know, the second reading debate is actually about the policy of the bill. If the bill passes at the second reading stage, we will then consider the detail of it. It has been interesting to listen to a number of the arguments, and whilst I accept that the detail of this legislation is important, a lot of the comments made in this house and publicly have been that the detail of the bill is not sufficient to warrant it merit. I believe that if the people who made those comments believed in the policy of the bill, they could work with the members of the chamber who also support that policy to arrive a bill that actually had the detail required for a piece of legislation such as this.

The other thing I found very interesting in considering the community reaction to this bill is that there has been a fairly wide acknowledgment that in some form—I know people have argued the point and I will come to it in more detail later on in my speech—there have already been occasions when the ending of someone's life has been enhanced as a result of medical treatment. That may have been through palliative care or otherwise, but it was known that providing that treatment may have brought forward the end of a life, and one could argue that this bill will legislate for those practices and provide a framework.

This bill also raises the question of what do I and what will we collectively, as a Parliament, say about the question of life, and, for want of a better term, the sanctity of life; the importance that we place on life and how people live it? What is it and what does it mean? Unfortunately, I am not a great philosopher; I am sure others are far better equipped to ask and answer those questions. But it made me think about whether life is always the primary consideration when we, as a Parliament, pass legislation or collectively make decisions in this chamber. It may be through accident—I am not suggesting that we make those decisions with clear intent—that we make, or fail to make, decisions that can have an impact on life and the way in which lives continue in our community. I use road safety as an example of that. Please, this is not intended to be a political comment about political parties; it goes for governments of both political persuasions over a continued period of time, and I think it is fair to say that there has been a continuum of trying to reduce the road toll. But the studies and evidence is out there that shows that we could make decisions tomorrow as a Parliament that, estimates would suggest, would

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probably halve the road toll. We all seek, and always should, to get the road toll down to zero, but we, as a Parliament, have not made those decisions, and I mean that as a Parliament collectively.

When some of those decisions come before us I suspect that we will continue to potentially not make decisions that would actually save lives on our roads. Some 200 people a year die on roads in Western Australia. Estimates show that if we applied some of the strategies that are available to us we could, in that path towards zero, reduce that road toll by over 100.

Hon Ed Dermer: Is it a matter of money?

Hon KEN TRAVERS: I think it is a range of things. It is about money, it is about attitude, it is about us making tough decisions and it is about how we apply the law under the Road Traffic Act. We could take a whole range of issues that would help reduce the road toll; it is not just money. We make as many other decisions as a Parliament that affect and impact upon life. People's lives will be ended, often in a random way in some respects, without our making that decision. I put that on the record.

I contrast that with one of the other things I looked at, which is the situation in Oregon. Hon Lynn MacLaren looked at that in great detail. I looked at the number of people who have exercised their rights under the Death with Dignity Act in Oregon. Of the people who seek a prescription some end up not using the prescription that is available to them, others die of the underlying causes of their disease and there are a number of other reasons. From the figures that I could obtain, the maximum number of people who died in 2008 as a result of the Oregon Death with Dignity Act was 60 people. It should not be a numbers game but it is an interesting situation that makes one have to think about these issues.

I listened to those who have said that there is a danger here that we will create a situation in which people will be pressured into euthanasia. It is a sad fact of our society today that already people are pressured into circumstances in which their lives, in my view, are shortened. Their lives are shortened as a result of a whole range of pressures that are either placed on them by us as a community or by individuals within their families in the community. I do not want to make it into too simplistic an argument, but I have heard it said that when people go into a nursing home, it is often the beginning of the end. I am someone who believes that we can encourage someone to lose the will to live and so pass away quicker than otherwise. It is certainly my view that those pressures are already occurring for many in our society. I think it is unfortunate. I for one certainly hope that I am able to be supportive of my parents to ensure that they always have the choice of staying out of a nursing home and have the support of their family so that is not an option. I do not know how many others have been in circumstances where they have been aware of one member of a couple passing and the other member of the couple dying very soon after. Some of us would say that is a good thing. I think we often think it is not necessarily a bad thing that that occurs. Those pressures on people are already occurring.

I noted the comments of Hon Ed Dermer and I agree with him. I do not think that opinion polls on their own should be the basis on which we make decisions in this place, or on this occasion, but I do acknowledge that there is clearly overwhelming support for the concept. If we accept that, and if we accept all the other points I have made, the vexed question is: is it possible to put in place a bill and the detail in a bill that will manage those issues as we move forward? Let us remember that in the case of this bill we are dealing with people whose lives are already terminal. It will need to have been established that they have an illness that will lead to their life ending in 24 months.

It is not about ending a life; it is about the timing of the ending of that life, and the way in which it is ended. I do not want to take this out of context, but I heard a member earlier make a comment along the lines of getting an expert in to make the decision about whether someone should live or die. When one is in that situation, the only expert qualified to make that decision is the individual whose life is to end.

I have listened to and noted the comments about palliative care, and I accept that, in all cases, that should be the first option. However, I also accept that, as good as palliative care is, it will never deal with all the issues that people have with the illnesses they face in our society today. It was also interesting to hear the Deputy Premier make the comment that he had been involved, as a medical practitioner, in giving treatment in the knowledge that there was a clear likelihood that the end result of the treatment may have been that the patient's life would end, albeit that that was not the primary purpose of giving the treatment.

To those who say that we cross a threshold at some point by passing this bill, I would suggest that that threshold has already been crossed in our community. I have tried to rationalise this. If we look at the process as a continuum, how do we identify the point at which the actions of the Deputy Premier, in his example of his experience as a medical practitioner, compare with what is proposed in this bill? When a medical practitioner knows that the treatment has the potential to end the life of a patient, at what point does that action correspond

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with what is contemplated in this legislation? I welcome philosophical discussions on this matter outside the chamber.

Hon Ed Dermer: I think it is intention.

Hon KEN TRAVERS: If part of the intention is the active knowledge that giving that treatment will bring forward the end of the patient's life, it is still an intention.

Hon Ed Dermer: That is a consequence.

Hon KEN TRAVERS: This is an important issue to wrestle with. Earlier tonight a member made the comment that there needs to be a broader community debate. Tonight's debate is part of that debate, and I suspect it will continue. As members of this chamber, I hope we continue to have these debates. I have noticed that everyone has their own position on this issue, but they have tried to engage in the debate. Unlike some debates for which there have been conscience votes, there has not been anger, hostility and animosity between members. I think it has been a relatively constructive debate in which people have attempted to share their views and their positions.

However, I find the matter very difficult to determine. The reality is that people can say that it is a matter of intent or consequence, but there is no doubt in my mind, having spoken to people who have been in those circumstances, that the point at which that additional medication is provided is an arbitrary choice. People make that choice knowing what the likely consequence of their actions will be. It is already out there in our community, and if we seek to deny that, we are denying realities.

The question then becomes: can we bring in legislation that helps define, quantify and codify those issues? That is, I guess, the question that we need to ask when we deal with the policy of the bill. If we are successful in supporting the policy of the bill, we will go into a debate about whether the protections and other details of the bill are sufficient to achieve what it is we are hoping to achieve. I must say that I do not accept that this is the thin end of the wedge. It is my view that these matters, whenever they are raised in this Parliament, will be treated with the seriousness that they have been treated with in this debate tonight. Therefore, any amendments to the legislation would be subjected to the same rigour as this bill and, listening to the people who have spoken in the chamber tonight, the rigour that everybody has applied to this bill. If we did pass this bill, it would not set up anything other than what we agree to in the passage of this piece of legislation. I do not think that it would set up a framework any more than those things that already occur in our society do. Like Hon Sue Ellery, I met with Marshall Perron. I found that the correspondence and communications I had with him were interesting and provided a number of points that challenged my views on this matter. One thing that I came away with from my conversation with him is that it is interesting that, as a society, we are living longer, but we are dying slower than we have ever done at any time in our society. I think that is one of those realities that we need to try to deal with as part of this debate.

Looking at this issue from a personal perspective, I am fairly confident that even if we pass this legislation, for me personally, I do not know that I could ever take that action; I do not think that that is the sort of personality that I have. If we provide the opportunity for people to make those choices if they face a terminal illness, I am fairly confident—I guess we can never be absolutely sure until we are in those circumstances—that I personally would never be able to exercise the option, and if I did decide that I wanted to, it would probably be too late to exercise the option in the way that the bill currently provides. That is the case for me personally but, interestingly, I have some very close friends and family members whom I suspect would not only exercise the option in this bill, but—this is one of the great fears that I have—they would also exercise the option to end their life without the dignity that this bill may provide. If some of my friends and family members were faced with a terminal illness, they may take it upon themselves in their own way and in their own time to end their life. I do not know whether that would absolutely be the case—it is only our close family and friends that we would even hesitate to hazard a guess about that—but in the conversations that I have had with members of my family and friends, I believe that for some that would be the case. I like to think that if we accept the arguments that I put earlier about that question mark about where on that continuum this is set, we might actually provide some opportunity for those people to make that choice with some dignity, whereas at the moment they are left without it.

Again from a personal perspective, the question has been raised about whether a person seeking to exercise their rights under the legislation would put unfair pressure on the family. I can only speak on these matters from a personal point of view, but I know that if a member of my family put something in a written format and exercised it under this legislation, it would make it a lot easier. I know what I would do; I would respect their wishes. What actually becomes a lot harder, which I have faced with decisions around family matters of life and death, is when it is not written and the family has to try to guess what the wishes of that family member are. To me that would be a lot harder. I believe that is when there would be far greater tension within a family unit.

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I return to the question about the point at which the enhancement of treatment in palliative care may bring about the end of a life. To some degree that issue is dealt with by the living will legislation; I fully accept that. But to me, having clear instructions from people who have executed a living will would make the situation very easy. For me the harder situation would be not having those instructions in a clear framework.

Having given this bill a great deal of thought, having gone back over it, particularly last weekend, and having considered and reconsidered it, I believe we need to set up a framework to deal with the situation that is already occurring in society. I accept that if this bill passes the second reading stage, debate at the committee stage will be very difficult and it will take a lot of work to put in place all the different protections and mechanisms that members have talked about. There have been times when I thought that the easiest option would be just to vote no. In some respects I think that is the easiest option we could take. For me personally, the easiest option would be just to vote no for the second reading of this bill. It would be easy to say that we as a Parliament should not worry about trying to work through the detail of the bill. But, having considered the bill and having acknowledged that the community wants us to put in place that framework, the challenge for us is to make the harder decision; that is, to support the policy of the bill, but then to work on whether we can put in place the framework to provide the detail. If we do not believe we have put in place the necessary detail and protections to ensure that the range of concerns raised by others in this place have been satisfied at the end of the committee stage, we have the option at the third reading stage to say no to allowing this bill to become law. That certainly is the decision that I have made and I will be supporting the second reading of the bill. If the second reading of the bill is successful and the majority of this chamber takes that position, I am keen to work with members to see whether we can work through and put in place that framework to deal with what is happening out there in our community today, and to provide a framework that will allow people to make that choice of their own with dignity and with all of the necessary protections that need to be in place.

I will support the second reading of the debate. I hope it is successful and that we can as a Parliament continue to work through and deal with the challenges that we will face in getting the detail correct.

HON HELEN MORTON (East Metropolitan — Parliamentary Secretary) [9.12 pm]: When I was reading this Voluntary Euthanasia Bill 2010, I did not get as far as looking at the technicalities of the bill. I needed to deal with the concept of the bill first and the ethics around it, and I did not really get into the bill in that sort of detail because I could not get past the concept of it. As for my fundamental beliefs, I am not a religious person; but I gather—I imagine anyway—that I might be what is called spiritual; I do not really know. Whatever it is, I actually have a very deep respect for human life and a profound respect for the human spirit. My views on this bill have been shaped by considerable personal experiences. Since I have become a member of Parliament one of my brothers has died from liver cancer; a brother-in-law has died from another form of cancer; and I have been with both my mother and my father throughout their dying process. In fact, my father came home to live with me for four months while he was dying. I have had a reasonable background in, and professional experience through, working in nursing homes. Some of them were secure facilities for severely affected Alzheimer sufferers. We do not often hear about the level of degeneration experienced by those people. For example, I will never forget a woman who brought in her baby to visit her mother, and her mother not recognising that it was a baby, and thinking that she was being given something to eat and was about to start eating. That is the level that sometimes Alzheimer's disease patients can get to.

I have had other experiences, and I have worked as an occupational therapist. At one stage I specialised in spinal injuries and worked at Royal North Shore Hospital, as well as here in Perth, working with quadriplegics, and I have worked with people with strokes and all sorts of things like that. I have done a fair bit of reading on this because I needed to balance my medical and clinical views in the work I was doing with the legal and ethical aspects of the bill before us. I have had numerous discussions with palliative care specialists. I emphasise that the discussions I have had are with specialists in the area of palliative care. Like everybody else, I have received hundreds—I am absolutely certain it is in the hundreds—of emails, letters and contacts from people from both sides of this argument. I have held meetings in my office with groups of people, so that I could get a better feel for this issue. Those groups comprised people who were pro euthanasia and people who were against it. I managed to ask people from around the East Metropolitan Region to spend an hour or so in my office and have cups of tea with me and talk to me about their views so I could get a better handle on how they felt about it.

One of the things that I did, along with Hon Nick Goiran, was to visit Christian Rossiter. We spent a number of hours with him before he got lawyers and what have you involved. I will speak a little about the reasons that we went to visit him. Hon Nick Goiran and I went for different reasons, I think, but together we made a good team. Christian was very appreciative of that contact, and I will talk a little about what this meant for me.

Extract from *Hansard*

[COUNCIL - Wednesday, 22 September 2010]

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Hon Michael Mischin; Hon Dr Sally Talbot; Hon Col Holt; Hon Lynn MacLaren; Hon Ken Baston; Hon Ed Dermer; Hon Ken Travers; Hon Helen Morton; Hon Max Trenorden; Hon Matt Benson-Lidholm; Hon Kate Doust; Hon Simon O'Brien; Hon Adele Farina; Hon Robin Chapple

In all of this, my views have boiled down to answering four main questions before I was prepared to look at the technicalities of the bill. The first question is: can extreme pain be managed, even right up to the point of death? The second question I had to answer in my mind was: can we effectively manage the belief of some people that they are a burden on their family, on the people closest to them and on the community or society—or whatever the term people want to use? The third question that I needed to consider was: can we effectively deal with the emotional suffering—the sort that would lead somebody wishing that they were dead, rather than continuing to live? I do not think that many of us have an appreciation of the extent of that sort of emotional suffering. The fourth question was: can we effectively deal with the extreme indignity a person may feel? Once again, the sort of indignity that might make a person feel they would rather be dead than continue to put up with what it is that they are putting up with. I needed to explore in my mind those four issues before I could come up with a beginning point on euthanasia.

In terms of the pain, obviously I am very aware of the range of palliative care options that are available, and have witnessed the benefits of those options in and around me over the past couple of years—at home, in a hospice, self-managed, specialist, and shared care arrangements between specialist, GP and home visiting nursing specialists in palliative care. I have seen it at work first-hand with my brother-in-law, who lived in Fitzroy Crossing. He had to come to Perth at the end stage of his horrendous cancer. I saw it operate at home for my brother, who had a very quick death. I think it lasted about four months from the time he found out he had liver cancer to the time that he died. He was a great big strapping six-foot-three man. By the time he died, he was a very thin, shrivelled man who could not get out of bed. Of course, I also saw it operate in my own home for the four months that my father was with us before he died.

The palliative care specialists to whom I have spoken made it absolutely clear that they can manage the pain. In the personal experiences that I have just mentioned, I saw it managed. We have a wonderful public health system. I heard someone say earlier today that it was thought that this level of palliative care would be available to people only if they had money. We have a fantastic public health system that provides palliative care in people's homes. My parents were pensioners. They did not get additional funding to help with that process. I do not believe that getting good palliative care is dependent on money; I think it is dependent on good education, knowledge and understanding of what is available.

Hon Ken Travers referred to the intent of doctors who provide, under the palliative care program, a level of pain relief or sedation that will eventually result in death. I have never had doctors tell me that they have a problem with that. If a patient requires a level of sedation or pain relief that is necessary for that patient to be relieved or to be comfortable, doctors will administer whatever level is required. If a person dies as a result of getting that comfort or pain relief, doctors are comfortable with that, as am I. The intent is to enable the patient to be comfortable through pain relief. Once again, I have seen it and it works. As everybody has said, it happens all the time. I cannot understand why, if it works, if it is available under the existing system and if it has natural safeguards built into it, why would we want to go any further than that? That is the bit that I find a little difficult to understand. I understand that it is a specialist type of medicine. It should be available to anyone and everyone who needs it. We need to ensure that doctors and nurses, and the general public for that matter, are better educated in terms of clinical knowledge, ability and skill to undertake this form of specialised care, and are better educated about their legal rights. I can remember when we dealt with the consent to medical treatment bill that people were not sure even then about the legal rights of the work that they could do under that legislation. We built into that bill an education program so that doctors and nurses would be made more aware of their legal rights.

I repeat: if this is working and if it provides the kind of comfort that people in the most extreme pain require, we should continue with what we have. I reiterate what many other people have said: pain management involves specialised care. It has progressed immensely over the past five or 10 years, and it will continue to improve. I can assure members that I have a very low pain threshold. The last thing that I want is to be in a situation in which I would have to experience the type of pain that members have talked about. However, I am convinced that that level of pain is absolutely manageable and I feel comfortable about that.

When I was listening to Hon Lynn MacLaren talk about the polls, I was concerned about the wording of the polls that generates a certain public response. I cannot remember the exact words used, but it was something like “if there was extreme pain?”. If someone asked me whether if I had to endure extreme pain I would do almost anything to get out of it, I would say yes. The use of that sort of language in a poll seeks the response that it got. If the poll asked: if you had a reasonable chance of pain being managed so long as you could get access to this service and you would have a reasonably comfortable life, would you support euthanasia? I wonder whether the answer would have been different.

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I will talk also about the issue of being a burden. Many people I met, particularly those I have met in my office, wanted control over the type of decisions that are now available to them under the amendments made in the Acts Amendment (Consent to Medical Treatment) Bill. That is new legislation that has been enacted in only the past six months, I think, and therefore people have not had time to get a good handle on it, which I can appreciate. However, I was absolutely amazed at how little people understood about what treatment was available to them under that legislation. I was amazed at how many people confused that legislation with euthanasia legislation. They thought that a euthanasia bill would give them the sort of control that they can get under the consent to medical treatment legislation. I told them that they can do those sorts of things now and that they do not need euthanasia legislation to refuse treatment. It was like having an education session with them. Most people are very aware that the consent to medical treatment legislation enables them to refuse any treatment, medication or other artificial means of keeping a person alive. That includes tube feeding and drips for hydration. As long as a person is of sound mind and does not have suicidal ideation, he can refuse any type of intervention regardless of whether or not he has a terminal illness. That is the course Christian Rossiter chose. When Hon Nick Goiran and I saw Christian, it was before he had become involved with the courts and lawyers and the big hoo-ha that occurred. I visited him to make sure that he understood what his rights were. The medical consent provisions enshrined in legislation what was already common practice. I visited him to make certain that he understood that and told him that if he needed someone to advocate for him, I would do it if that was what he wanted. We did not just bowl in there. We sent a message asking whether Christian would like to see us and he readily agreed to that. I was interested in trying to understand whether Christian had suicidal ideation. I am not a clinical psychologist and could not clinically diagnose him, but I wanted to talk to him and see whether I could pick up any signs of suicidal ideation.

Hon Ed Dermer: What does suicidal ideation mean?

Hon HELEN MORTON: It means wishing to suicide—believing that one wants to suicide.

We had a very full discussion with Christian. He had a tracheostomy, so we had to be careful how we spoke to him because he had to cover the area he was breathing through to enable the air to come out of his mouth sufficiently so that he could talk to us for a certain amount of time. We had to measure the discussion that we had with him so he could respond appropriately. He complained to us that the staff were refusing to take notice of his wishes. He had indicated that he wanted to cease feeding and hydration artificially but the staff had not taken any notice of his wishes. I noticed that because of his tracheostomy, he was having regular aspirations. Normally we can cough up a bit of phlegm through our mouth but when one has a tracheostomy, one cannot do that. He would need aspirating on a fairly regular basis. The nursing staff mentioned to me that he did get anxious from time to time when he felt that he needed aspirating.

I spoke to the CEO after I met with Christian. She was really concerned that he may be suicidal. I was aware of Christian's past history of suicidal ideation. She needed to clarify whether she would be in breach of care if she went along with his wishes, on the basis of his past history. Everybody knows the story. He subsequently went to court and got a medical certificate to say that he was not suicidal but he was fit and sound of mind. The CEO wanted confirmation that the agency that she worked for could comply with his wishes. That was all clarified.

As I said before, I found him to be a really interesting man. Even though we were with him for only a couple of hours, he said that he felt that his life was pretty empty. His eyes lit up with the visit. I thought I was doing the right thing when I said to him that we were not there to get any publicity around his situation. He let us know in no uncertain terms that he wanted publicity, thank you very much, and if we were not there to get him some publicity, perhaps we ought to rethink our visit. We called that one wrong. We were not subsequently involved in any of his publicity. I got the impression that there were things that he would live for—things that he wanted to be involved in. He liked the idea of the lawyers becoming involved, the court case and the publicity surrounding that. The facility around him assisted him in pursuing that. He was talking about going overseas. That generated more publicity. As was mentioned, he eventually got a chest infection and refused the treatment to clear that, so he died. I think everybody has made the comment—it is quite right—that Christian would not have been helped by this bill because he did not have a terminal illness.

As I mentioned before, I have worked with many quadriplegics. I do not know how much members know about that kind of injury. If one has a C3 injury and can barely breathe, one can survive. People with a C4 injury have no capacity to undertake any daily living skills, whether it be eating, drinking, toileting, dressing, moving around or turning on a television to whatever station they want to watch. These were some of the things that Christian was talking to us about. He was not able to make things happen the way he wanted or when he wanted. He was very frustrated about the fact that he could not watch a show on television because when he wanted to turn on the TV or change the channel at the time that he wanted it changed, no-one was available to change it for him. When I worked with these people in the quadriplegic centres et cetera, I was amazed at how they did not feel that they

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did not want to live. I have worked out that, although they too had the living wills legislation behind them, they had an entire hospital department dedicated to assisting them to believe that they had a future, to find purpose and value and to reinforce and reassure them that they were valued and there was some way they would live a fulfilling life. Occupational therapists, physios, social workers, psychologists and psychiatrists as necessary—a team of people, apart from family, and we worked with family as well—were employed to work with these people. The majority of the patients were young men. They were able to see that there was some way that their life had purpose and value. We worked with the people around them to make sure they were not projecting any of their own emotional suffering onto them. We worked a lot around the dignity and indignity aspect, and I will talk about that in the future.

Interestingly, these people would not be covered by the bill, despite their having all the need for compassion, as the member put it in the bill. I am interested to know why.

Hon Robin Chapple: It is a slippery slope.

Hon HELEN MORTON: I will tell members my views of the slippery slope. Some time ago we passed an abortion bill. I was not around; I do not know who was.

Hon Max Trenorden: I was.

Hon HELEN MORTON: Okay. Supposedly abortions were legalised to enable terminations by mums whose psychological or physical health was at risk if they went through with the pregnancy. It was dealt with in a way that meant if a mother's health was at risk, abortion should be allowed to take place.

Hon Ken Travers: That was the law prior to the changes.

Hon HELEN MORTON: By the time I left as the CEO of Armadale Health Service, the single largest number of surgical procedures being undertaken at the hospital were terminations. They have become run-of-the-mill procedures. If we want to talk about a slippery slope, that is one that was before my eyes all the time.

Hon Robin Chapple: That is what the legislation was for.

Hon HELEN MORTON: People make use of it. That is exactly what I am saying. As soon as that legislation was in place —

Hon Robin Chapple: The legislation was very broad.

Hon Adele Farina interjected.

Hon HELEN MORTON: I have the figures from the hospital for the type of procedures being done.

Hon Adele Farina: Not through the hospital but also elsewhere.

Hon HELEN MORTON: Is that as a backyard procedure? No, they would have found a way to do it in the hospital system.

Hon Ken Travers: The circumstances you are talking about were the circumstances that occurred prior to the last debate this chamber had, which led to abortion and provided a framework for people to have an abortion without those criteria you are talking about.

Hon HELEN MORTON: I am saying that, once that legislation was put in place, the use of it increased to the point at which the number of procedures being done at the hospital was the highest because it had legislation to support it. That is the slippery slope I am talking about. If we pass legislation, it will be made use of again and again, and will become commonplace.

Hon Robin Chapple interjected.

Hon HELEN MORTON: Not according to my understanding of how it would happen.

I want to talk now about a person's feeling of being a burden. I thought: where on earth do I start with this? As children, we do not think that we are a burden. Does anybody know any kids who think that they are a burden to their parents? Even severely disabled kids believe that it is their right to be cared for. Even severely disabled kids have an expectation that they will be cared for. For people who are terminally ill and at the end of their life, this sense of—I hate this phrase, but it is a common phrase that is used—the “burden of disability” is quite short. However, for babies who are born severely disabled and who have their entire lives ahead of them, the burden of disability is very long and also very costly in terms of providing the support that they will need for the remainder of their lives. This bill focuses on the terminally ill. One of the things that needs to be considered in the debate on this bill is this issue of being a burden. We do not contemplate killing children. I know that sometimes

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services are not provided to children, and that children sometimes die as a result of how they are born. But we do not contemplate killing children. It seems that, overall, human beings have great repugnance for killing other human beings, particularly children. As adults, we have learned behaviours, values and judgements that shape the feelings that we have about being a burden. Those behaviours, values and judgements are not behaviours, values and judgements that we are born with. They are acquired learned behaviours, values and judgements. I am of the view—I have seen it happen—that these acquired learned behaviours, values and judgements can change. We can actually work with people to alter their sense of whether they are a valued member of society, or a burden. I do not believe that we can ever contemplate putting in place a bill that may enable people who believe that they are a burden to themselves, their family or society to decide to not be a burden anymore and to finish their life.

I want to talk now about emotional suffering. I was amazed again by the people who visited my office in small groups and the fear that they had about terminally ill people. I was amazed by their fear, their emotional trauma of having to watch and wait, not knowing how best to help, or not help, and by their sense of helplessness and hopelessness. I was absolutely struck by the level of emotional trauma that those people felt for themselves. I have seen people transfer that to the ill person. I have seen people transfer the guilt or the burden or the depression that they might have. I do not know the extent to which people are familiar with the idea of projection and transference of emotional suffering, but I can tell members that it is absolutely real. It happens. I would, therefore, caution members again about voting for this bill, because this bill may enable people to choose to die just to end the suffering of those around them. That can be better managed, and we need to provide more assistance to people who need it so that they can manage and deal with their own emotions.

I had not realised my time had nearly come to an end, but I wish to talk about indignity, which was the most difficult aspect for me to deal with. I felt like I could tick off the pain, I could tick off the burden, I could tick off the emotional suffering, but the indignity aspect was the most difficult. The sense of indignity arose from the concerns expressed by Christian Rossiter—I am about to be quite blunt, and I apologise if this is offensive to anybody—I cannot imagine too many things more undignified in the management of someone's personal care than the manual extraction of impacted faeces, but that sort of thing is a reality for many people. Christian talked about not being able to taste anything and he said that food was of no consequence and did not bring him pleasure et cetera; but, at the same time, I find it very interesting that some people will put up with the most amazing what I might call lack of dignity, while others, such as myself, have a very low threshold. I do not know about other women in this chamber, but I find great indignity in having my mammogram done every two years. I do not know how many people have had two-yearly or three-yearly colonoscopies, but they are pretty undignified.

Hon Liz Behjat: There's nothing undignified about it.

Hon HELEN MORTON: I am saying that it can feel like that to some people.

I tried to understand why some people can deal with indignity and some cannot. I turned to one of my favourite authors for assistance—namely, Margaret Somerville, professor of law, professor in the faculty of medicine, and founding director of the Centre for Medicine, Ethics and Law at McGill University in Montreal. She is a regular consultant, nationally and internationally, and she has consulted to the United Nations. She has received many honours, including the Order of Australia, and in 2003 she became a recipient of the United Nations Educational, Scientific and Cultural Organization Avicenna Prize for Ethics in Science.

She wrote a book that I read from time to time called *Journeys of the Human Spirit*; it is in the Parliament library if any wants to read it, but I have my own copy at home. In that book she wrote about the concept of indignity, and wrote about it in terms of whether we value the concept of intrinsic indignity or extrinsic indignity. Those two concepts help us to work out why some people can suffer the most amazing what we might call indignities, and other people can sail through them. But, essentially, her point is that voluntary euthanasia subordinates the concept of respect for human life below respect for human dignity; I will quote Margaret Somerville —

Whether the concept of respect for life and that of dignity are compatible or in conflict can depend on which concept of human dignity we espouse. If humans are seen to have intrinsic dignity (that is, dignity simply because they are human), there is usually no conflict between respect for life and for the person's dignity ... Extrinsic dignity means that dignity is a matter of assessing the situation in which one finds himself. In other words, dignity is conferred on a person; it is not innate simply because one is human. The concept of extrinsic dignity is much more likely to result in a conflict between respect for life and for dignity. This occurs when upholding the person's dignity is seen to require that respect for life be breached — as in ... euthanasia. To put it another way, respecting the person's dignity is seen to require upholding their right to autonomy ... extrinsic human dignity is closely linked to ... upholding

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individuals' rights to autonomy ... whether we have dignity and what is required to uphold it all depends upon the circumstances in which we find ourselves.

If your primary value is personal autonomy and self-determination, then dignity will be used to establish and reflect that by giving priority to those values. Likewise, if your primary value is respect for life, dignity will be used to give priority to that value.

Basically what she is saying is that if people have an intrinsic concept of dignity, they are afforded dignity by being human, and that is the preciousness of human life, but if people determine dignity by what is around them—an extrinsic concept of dignity—then their dignity will be determined by the circumstances in which they find themselves.

As I mentioned before, I will just tell members about a couple of examples of this from my own personal experiences. My mother managed her death by the consent to medical treatment course. The weekend before she decided to take that course she and I had a game of Scrabble. She was the most amazing wordsmith and she thrashed me yet again. But she had had bilateral hip replacements that had got infected. She was told that the only choice for her was to have those hips out, that the infection had to be flushed out and that the whole process was going to take three months and she was going to be totally bedridden for three months. She had a very severe skin infection at the same time, which was a type of skin leukaemia. I can understand now why she thought she was a burden to us. She had made a decision with my father and the doctor. She did not want us to know about it because she did not want to have to deal with us on it. I went off to the Dowerin Field Day. I got a phone call on the way saying that mum was in hospital again. I thought, yes, mum had been going frequently to hospital so there was no big deal. I was told that I might want to see her when I got back from Dowerin. I said okay. By the time I got back from Dowerin she had a level of medication that meant that she was heavily sedated. She opened her eyes only once, and that was when I made some dreadful remark, such as, "Do I snore as loudly as that?" She opened her eyes and looked straight at me, but after that game of Scrabble that was the only time I had a personal contact with her.

Hon Ed Dermer: She still had the look to put you in your place, did she?

Hon HELEN MORTON: Absolutely. I know that she felt a burden because we had warned her not to have those hip replacements, telling her that the risk of infection was too high. We told her not to have it done because if she got an infection, she would be bedridden and so on and so forth. We therefore partly assisted her to feel the burden that she felt. She made the decision with my father and the doctor to go into hospital, refuse any form of treatment or any form of hydration or nutrition. She died within 10 days. I was with her for most of that time, except for the time when I had to have a sleep, of course. I can honestly say that she was not uncomfortable. She had what I would call a peaceful time. There was no groaning or moaning or any indication, in my mind anyway, that she was uncomfortable. Her system was basically just switching off in that time frame. It took 10 days. Why is Hon Robyn McSweeney screwing up her face? I do not think that is too bad. It was not bad at all. She was not uncomfortable in that time.

Hon Robyn McSweeney should wait until she hears about my father! He was a sterling old chap. He came home from hospital and lived with us for four months with his severe diabetes and complications. He was one of those men who lived that intrinsic dignity right through to the end, because who would have thought that a man like that could put up with the indignities of daughter, son-in-law and other people providing every form of care for him as he slowly died? But he did and never once did he appear to be undignified in that process. Those four months were so amazing. He slowly ebbed away, dying. The last thing I think he had to eat or drink was his port, which he loved, and some honey. I do not believe in ghosts and all that sort of thing, but he would say the most amazing things to me, such as, "What are those people in the corner doing, Helen? Where are they taking me?" He was awake; his eyes were open. I wondered what on earth he was talking about and whom he was talking to. I had no idea what he could see or what he was imagining was happening, but I actually think that that is part of the process, and we should not circumvent that process. He learned to disassociate himself from these so-called indignities, but another amazing process was also taking place, and we were part of it. It was unbelievable.

I want to finish by saying that I believe we can and must improve our current processes around dying. We seem to be so fearful and use such fearful language when we talk about dying, yet my experiences in recent times have been otherwise. We can continue to improve pain management. People's attitudes about being a burden do not have to be like that; they can be altered. People can assist in altering those attitudes. Emotional suffering can be alleviated, but, more importantly, I believe that we need to ensure that we do not project or transfer onto people the emotional suffering that we are feeling because we are feeling so helpless and hopeless and do not know how to deal with it or alleviate their worry. The issue of feelings of indignity is something that we need to learn more about, and I do not think we have done enough about that at this stage.

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My feeling is that this bill will take the impetus away from making sure that we work towards those sorts of objectives, and for that reason I cannot support the bill. The risks and dangers involved in doing so far outweigh the potential benefits that could be gained.

HON MAX TRENORDEN (Agricultural) [9.57 pm]: Some years ago I was watching TV and there was a chat program featuring George Burns; I was a great fan of George Burns, who lived to be more than 100 years of age. He had his trademark cigar in his mouth and he was being interviewed by a presenter whose name I frankly cannot remember. There was also a lady being interviewed who was an expert in childbirth. She was explaining matters to do with childbirth and she said to the presenter that the first few seconds of life were very, very precarious. George Burns took his cigar out of his mouth and said, "The last three aren't too good, either!"

I do not have any problems about making a decision on this bill: I will not be supporting it. I have been a member of Parliament in the other place and in this place for more than 20 years, and I have had a conscience vote on every bill that I have ever spoken on, so I do not have a problem with this. Looking to my constituency, 36 constituents have emailed me about this bill; 34 were opposed to it and two were in favour of it. I say to Hon Robin Chapple that, just like the poll question, I know why those people have written to me; they are people with a religious belief, so I am not taking that as a measure, either, even though I have spent my entire political career supporting my constituency. I am one of those members who believe that my job here is to represent my people. That is what I do and I have done that fearlessly, I would argue, over a lot of years.

I would suggest that there just is not any passion for this bill out there. My electorate office is at the main entrance of the shopping centre in the town of Northam. When that terrible, terrible bill called the Daylight Saving Bill was before the Parliament, people would fling my door open and scream into my office, "Don't you dare support daylight saving!" That did not happen once with this bill; it would have happened more than 100 times to me at my office with the daylight saving legislation. The correspondence I got from my constituency, not outside of my constituency, was in the thousands, not the tens. It was the same with that terrible, terrible oppressive bill called the Retail Trading Hours Amendment Bill. There was far more emotion out of my electorate for that bill than there is for the Voluntary Euthanasia Bill. Mr President, as you know, we are in the circuit for shows at the moment. I have been around my electorate at the Dowerin field days, the Mingenew field days, the York show, the Beverley show—name it, I have been there! Do members know how many people have raised this issue with me from the thousands of people with whom I have spoken in that process? None! I have had a raft of other issues raised in those conversations, but this issue has not been a centrepiece or a talking point.

An acquaintance I see from time to time runs a crisis ward in a very large hospital in another state. He tells me that he has the capacity to save about \$1 million or \$1.5 million a day by allowing people who have come into that crisis ward to die. He spends that money, that \$1 million or \$1.5 million a day, saving people for a day or two days or three days. We do that out of compassion. We do that so that if a young person has had a car accident, the parents can turn up—all those issues related to compassion. I am sure that no-one in this chamber would say it is more important to save the \$1 million or \$1.5 million. I am not saying that this has anything to do with Hon Robin Chapple's bill; I am simply talking about the attitude of people. However, I think it is important that we look at that.

I want to make it clear that I am not a supporter of any church. I actually lie every time the Census comes around; I mark "COE" on my form because I cannot think of writing anything else on it. However, I am not a supporter of any church; in fact, I am pretty much agnostic. Churches irritate me enormously but I am a believer, so members can take that whichever way they want. I do not have a religious view on this subject. I have what I would consider to be a moral view, but it is not a religious view. I was in the other place for the very vexatious debate on abortion. It was a very, very hot debate. In fact, a personal friend of mine called across the chamber and called me a murderer. Debates do not get much hotter than that. I voted, if members want to have a look at the record, pro-choice. That is what I did. The reason I voted pro-choice is that I had overwhelming support from my electorate for me to do that; literally thousands of people came to me and pressed me to do that. It was my responsibility, in my view, to stand beside my constituency. That is what I have done, or I hope I have done, to the best of my ability during the course of my time as a parliamentarian—it could be called a career or whatever. However, I also have an interest in life, like all of us in this chamber, and I can tell members of many, many occasions, one very recently, in which a couple from a lovely family were married for more than 60 years. The husband died and the wife attended the funeral a week later and then died. She decided to die. In the term of my life, I have seen that on many, many occasions. Only last year the father of a good friend of mine called him and said, "Come and see me this week because I've decided to die"; and he did die.

I therefore believe in the human spirit aspect in that people do have control over their lives and I believe that many people do choose to die, and do die. Hon Robin Chapple would not argue with me that Aboriginal people

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do that on a fairly regular basis. There is therefore a concept here that I think is important. I am therefore going to be a hypocrite and quote the Archbishop of Canterbury from his address to the General Synod in England. I will quote from this, not because I am a great fan of his church, but I am actually a bit of a fan of Rowan Williams as a person, I have to say. If he were standing here in this place, I would tell him that, but I suspect he will not be reading my contribution in *Hansard*. I want to read two quick quotes of what he said on Tuesday, 9 February 2010. The quotes are, obviously, not to do with Hon Robin Chapple's bill, but they are to do with euthanasia, which is being debated in the United Kingdom. The two quotes I chose out of the page and a half of his address are as follows —

The Church does not assume that it has the right to impose any solution; but it will argue fiercely, so long as legal argument continues, that granting a 'right to die' is not only a moral mistake, as I believe myself, but the upsetting of a balance of freedoms.

Further on he says —

But most of us here, —

That is, referring to the Church of England process —

I suspect, would say that the balance of liberties still comes out against a new legal framework, and in favour of holding to the principle — not that life should be prolonged at all costs, but that the legal initiating of a process whose sole or main purpose is to end life is again to cross a moral boundary, and to enter some very dangerous territory in practical terms. Most of us would still hold that the current state of the law, with all its discretionary powers and nuances about degrees of culpability in extreme cases, serves us better than an opening of the door into provision for the legal ending of lives.

That is the best quote I could find for how I feel on the bill.

HON MATT BENSON-LIDHOLM (Agricultural) [10.07 pm]: Like all other members thus far, I welcome the opportunity to make a few remarks on the Voluntary Euthanasia Bill 2010. From the very outset I say that, like a number of other members, I have had many emails and correspondence, and the occasional phone call from constituents about this bill. I am also pleased to report that I have also had correspondence and emails from people outside my electorate in the Agricultural Region, certainly from my home town as well. As a member of Parliament, that is quite reassuring; although I do not imagine it would be too much fun getting the number of emails and pieces of correspondence I got for this bill for every bill that we ever get in this place. Nonetheless, on such a contentious issue, it is certainly reassuring that constituents are prepared to seek out the support of a local member.

I also want to acknowledge the many contributions thus far given by members. I found them all particularly interesting, some of them very challenging and some of them very thought provoking. Hon Ed Dermer always puts forward some very thought-provoking ideas. Hon Sue Ellery made a few very pertinent remarks and suggested that if this bill were to be defeated at the second reading stage or beyond, euthanasia is an issue that probably will not go away. I accept that, although, as will become obvious very soon, I do not necessarily agree with her sentiments on the nature of this bill.

Hon Michael Mischin, in a very voluble and eloquent speech, made mention of the issue of suicide. He made some pertinent remarks that I agree with. Hon Sally Talbot in her criticism of the bill made a particularly interesting point about the narrow nature of the bill. She went on to suggest—this is something that a number of members picked up afterwards—that the bill would probably change in the future. I think the words Hon Sally Talbot used were that there was a certain inevitability about change if this bill were to get through this chamber because of its rather narrow nature.

Hon Col Holt mentioned values, and I would concur with his sentiments about values. To me, this is an issue about values and beliefs. It is not something that I resile from in any way, shape or form. Basically, I am not here to convince anybody. I am not here to convince my constituents, because from my point of view I have been given a free vote and what people listen to is what makes me tick. What I am voting for and why I am voting for a particular decision is something that I will take on board as a responsibility to myself. For me, it is a matter of principle, and I think it is a fairly black and white sort of an issue. However, having said that, it is always important to inform constituents of exactly the issues that I am talking about and why I am voting for a particular issue and what the substance is behind it, so I need to give some assurances. I can assure my constituents of the following: this is a decision for me that probably did not take a lot of time and thought, but it is something that I have internalised over the past 35 years or so since I was at university and then in life. It is a decision that I am happy with. I am committed to this decision, and having said that, it is something, more than likely, that I am unlikely to change. If this particular bill were to go through the changes in the future that some members deemed

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appropriate, I would not necessarily be supporting those because my values and beliefs are things that are important to me, and as I have indicated before I do not see myself changing from that. Although, having said that, obviously in public life and in the sorts of things that members of Parliament do and get involved in, there are many things about which we do change our point of view. However, this issue is something very important to me. Like Hon Max Trenorden, I do not think it has anything to do with religion; it is something about how I was brought up and how I was encouraged to think and to question things. I probably came to this particular view a long time ago. For that reason, as I say, I am more than likely not going to change.

Whilst I do not intend to talk for any great length of time, I wish to make a few remarks about voluntary euthanasia generally and this bill in particular. I suggest that the thing that makes debates such as this one quite contentious is that we are talking about something very, very critical and personal. For all of us, sooner or later, it will become an end-of-life issue: how we pass on to the next life, if you will. For the people we are talking about, quality of life can change significantly—for them, together with family, friends and work mates—when they are put into the sort of situation that I am sure most members know plenty about. This bill is obviously not about kids or people under the age of 21, and for that reason I suppose it is quite a narrow bill.

Associated with the diminution of the quality of life that members have talked about—Hon Helen Morton particularly talked about a certain diminution in the quality of life—there is much pain and suffering, there are certain frustrations, there is a desire not to be a burden, and there is a loss of control of bodily functions. I have a particular interest in sufferers of motor neurone disease. MND is a dreadful disease. I had a family member who was heavily involved in that sphere of health care for a number of years. I have met many people who were or currently are sufferers of MND. It is a dreadful affliction. A few more issues associated with the diminution of the quality of life include depression, physical stress linked to an illness and mobility problems. There are certainly many issues associated with the diminution of the quality of life. As members will appreciate, these are very emotional issues, and one must acknowledge such when debating a bill such as the one before us.

As a number of members have pointed out, central to any voluntary euthanasia discussion is the role of doctors. This point was made by Hon Brian Ellis. There are particularly pressing issues in relation to doctors that are not addressed in the bill. I know that the Australian Medical Association is concerned about this very issue. In my humble opinion, doctors should not have to do anything whereby the only intention is to end life. That is obviously central to the bill. Doctors have, as one of their principal obligations, the simple task of pain relief. The doctors to whom I have spoken have very much questioned their role in all of this. It is not something that they embrace at all. Euthanasia is treatment for the specific purpose of bringing about the end of a person's life. This is something that I cannot accept. There is also the issue of duress. Returning to the issue of doctors, what qualifications do doctors have to determine such matters? I think we would be placing doctors in a very difficult situation. Will doctors really want to make those sorts of decisions? As I have indicated, I think the answer is no. Doctors do not want, and should not have, the responsibilities placed on them that this bill requires. I cannot see any other person or expert being involved, given the nature of Hon Robin Chapple's bill. Doctors can either treat people or assist in life termination. There is obviously a certain incompatibility about that. Even though I do not mean to simplify the debate or the issue at hand, that is basically what it amounts to.

I would like to quote from a speech given by Dr David Watson, the clinical dean at St John of God Health Care in Subiaco, at the euthanasia and palliative care forum on 12 August 2010 at the University of Notre Dame Australia. If I come from any particular position, it is exemplified by Dr Watson's quote. Dr Watson said that legislating in favour of euthanasia is no substitute for better research, better clinical care, better employment of those tools we currently have and better palliative care. Dr Watson's comments underpin my approach to the conclusion of life's journey. Without going into the whys and wherefores, like most other members in this chamber, I watched my parents pass away, so I have some level of—I was going to say "expertise"—certainly knowledge of the issues at hand. I emphatically believe in that quote from Dr Watson. I must say also that one thing that disturbs me greatly is the charge that a person who is anti-euthanasia is not compassionate. That is not necessarily a view of members who have spoken in this debate, but it has frequently been mentioned in the press, and that riles me. That view underpins a lot of the comments made by people who write to newspapers. As far as I am concerned, nothing could be further from the truth. The passing of my parents is comfort enough for me in that regard. Certainly I am most proud of the compassion shown by the members of my family, no matter where they lived, and they live all around the state.

In supporting Dr Watson's stance, I will place on the record what I believe in when people must deal with pain and the treatment of disease in their last days. I do not object to patients choosing against what they consider to be futile and burdensome treatment, despite the fact that such treatment may be required to sustain life. Death in this instance is simply caused by illness, as far as I am concerned, which is fine. I also support the use of any and all means to alleviate the severest and worst pain—I take on board the comments made by Hon Helen Morton—

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despite the fact that such treatment may bring about death earlier than otherwise might be the case. In this instance, death may be foreseen but certainly is anything but intended. To my way of thinking, that is not euthanasia, but it certainly is compassionate. Withdrawing from what one believes to be unreasonable treatment to allow a person to die naturally is also legitimate, as is withholding the treatment, be it unreasonable or overly burdensome. There is nothing intentional about death in this instance; no-one has deliberately set out to end another person's life. That is a key and underlying point to my comments. I believe that the treatment of people in their final days or months must be done in a manner that respects the person in all dimensions of their humanity, including respecting the obvious fact of mortality. My fundamental stance, though, emphasises that for the good of both the individual and society at large, we need to counter the present moves towards euthanasia with a strong and consistent call for the extension of palliative care and other linked services. These services and palliative care would meet the needs of those in the most desperate circumstances. I believe that nature can then take its course and the best—I emphasise the best—and most appropriate palliative and medical care will support all people in their time of most need. That issue is certainly the most important consideration. I genuinely fear for the future if this bill is passed. Evidence in other countries, as Hon Ed Dermer and other members have mentioned, suggests that the best of intentions can have disastrous consequences for society at both the macro and micro levels. If I am not mistaken, I think Hon Nick Goiran, in his speech at the beginning of this debate, mentioned that very issue.

I acknowledge that this is a complex and emotive issue. What I am saying is probably making it even more emotive. As far as I am concerned, the desire to ease the suffering of loved ones has got to be a given. Certainly for me it is the central core of my argument. Of all the arguments put in favour of voluntary euthanasia, and there are a number, personal autonomy is cited as the critical reason for allowing people to seek an exit from life. This argument was seen as a key to allowing euthanasia in Belgium. Recent research, however, indicates that terminations of life without request or consent appear to be on the increase. This is a rather disturbing trend if these reports are true. If people are being euthanased without request, autonomy appears to lack any authenticity. A new pressure appears to exist in some pro-euthanasia societies according to a number of informed sources whereby some people with terminal illnesses may be encouraged—I know this point has been made before but I will reiterate it—for financial, family or other reasons to seek a termination of life. If that ever happened in Australia, it would be a very sad day.

In conclusion, I cannot support the second reading. I sum up by saying that euthanasia, once legalised, will be impossible to control completely. If this low-key bill is passed, further change would be inevitable. I think it would have to be. Euthanasia would increase pressure on vulnerable people. Euthanasia would significantly impact on the ethos of the medical profession. Euthanasia poses serious societal harms and issues. Last, but by no means least, I believe that end-of-life issues are more appropriately addressed by doctors following sound medical and palliative practices. I respect the opinions and views of those who do not concur with my opinions. In time, voluntary euthanasia may well become law. Maybe proponents will seek a referendum one day and it will be successful. However, I will always be true to the values and beliefs that I have today. As I indicated before, I cannot support the second reading.

HON KATE DOUST (South Metropolitan — Deputy Leader of the Opposition) [10.27 pm]: I also wish to comment on the Voluntary Euthanasia Bill 2010. Yesterday I received a phone call from a journalist from Sydney who said, "I understand you're not supporting the Voluntary Euthanasia Bill. Why don't you support voluntary euthanasia?" I thought about it for a second and I said, "I have always had a problem with people being killed and I suppose it is as black and white as that for me." I have always held that view and I have always been very concerned whenever these types of debates have arisen. Having read Hon Robin Chapple's second reading speech, I have some sympathy for him and his reasons for introducing this bill. As demonstrated by a number of members over the past couple of days, we have all had our own personal experiences in which we have suffered the loss of loved ones. For my way of thinking, I do not think we as a community really know how to come to terms with death and manage that well. I do not think we know how to grieve. I listened to Hon Ljiljana Ravlich, who talked about that aspect in her speech. As a community perhaps we are not too sure how to manage that or we have changed how we manage that over time and we have forgotten how to celebrate the life of the individual as well. The debate was fairly cut and dried yesterday.

I thought about the issues and I had an opportunity to look through the bill. I wish to pose a number of questions. One of the first questions that arose for me—I think it was flagged by Hon Brian Ellis—is that doctors do not have appear to have been consulted. In the past day or so we have seen the medical fraternity, through its lead body, the Australian Medical Association, coming out quite loudly saying that it does not support this legislation. In fact, a number of doctors have said that if this bill is passed, they would change their method of

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practice and go back to being a GP because they felt that this type of legislation would contradict their *raison d'être* for going into a medical practice. I can understand that. That is a concern.

I looked at the AMA website. I am not sure whether other members have had that opportunity. I encourage them to because the AMA has very clearly articulated its position on end-of-life care in great detail. Once members have read that, they will fully understand where it is coming from. I am not sure whether this statement has been provided to members. It states —

The AMA believes that the primary role of the medical practitioner in end of life care is to facilitate the provision of good quality patient-centred care that emphasises continuous, open, informed communication and collaboration between the patient, the health care team and, where appropriate, the patient's carers, family members, and/or surrogate decision-maker.

I thought that, as an opening statement, that says it all. It then goes into further detail and I felt quite comfortable with the AMA's position on these matters. We were afforded the benefit of some briefings, which a number of members attended, with Dr Skerritt and Dr Dean, and, I think, with a couple of others over a couple of sessions, who went through these issues with us and talked about what is currently available for people in end-of-life situations. I came away from those briefings quite comfortable in the understanding that in the current medical scenario, there are very rare occasions on which they would not be able to provide pain relief. There are very few situations in which people cannot be given some form of pain relief to get them through that period. As time progresses—Hon Robin Chapple pinpointed an incident of 25 years ago —

Hon Robin Chapple: It is a long time ago.

Hon KATE DOUST: It is a long time, and, as has been noted by other members, we know that technology, knowledge and drugs have improved over that time. Given the speed of that change, I imagine it will move even faster over the next few years. I am, therefore, confident we can get better.

I pick up on the theme that has arisen throughout this debate from virtually everyone, be they supporters or opponents of this bill; namely, that there is real concern about palliative care in this state. That is an issue. If we are dinkum about doing this well, perhaps across the political spectrum in this chamber we need to pick up that issue and have a really good look at how palliative care is structured and operates in this state and what we can do to make it better and more accessible. Hon Alison Xamon and a number of others talked about that aspect, and I agree with them. On some occasions, petitions have been tabled in this place specifically about that issue. It is a shame that we have not dealt with that matter in a better way. Perhaps it is something we can look at in the future. But other issues are associated with that matter. It is not just palliative care; it is before we get to that stage.

Hon Ed Dermer talked about the health system. Although people talk about it being a bottomless pit in terms of the money we put into it, we need to do that a lot better. For a lot of people who become ill, be they young or older people, going through the waiting periods, seeing specialists and finally getting a diagnosis can be quite debilitating, and can lead to depression. When we had the briefing with Dr Skerritt and Dr Dean, one of the issues they talked about was depression. People do not talk about the issues associated with managing a diagnosis of terminal illness and dealing with depression. Of course, people will be depressed when they are told they are going to die. When people are depressed, they will wonder, "What am I going to do, what is the value of my life, how do I move forward, or should I end it?" It is a very difficult situation. Maybe there needs to be more emphasis on how we deal with the issues associated with the diagnosis of a terminal illness. That is a real area of concern.

There has been a lot of discussion about what is happening in other countries. I have been very concerned about what has happened in Belgium, Holland and Oregon. In Belgium there has been the introduction of voluntary euthanasia, and that has moved on to being not so voluntary. The numbers have increased and changed and it has been recorded that many hundreds of people have been involuntarily euthanased. I understand that earlier this year there was a move afoot in Holland to have euthanasia open to everyone regardless of whether they have a terminal illness. That is a grave concern. I would hate to see that happen here.

Members have canvassed issues of burden on family and of medical situations. Sometimes people talk about euthanasia being an economic solution. I imagine a lot of pressure is put on hospitals to move people out or to move them on. I read a snippet of a story about a woman in Oregon who had been diagnosed with cancer. Obviously the health system in Oregon is very different from our system—I am glad we have our system and not their system—and her medical fund would not give her the tick-off to get the appropriate treatment for her cancer that might enable her to go into remission or be cured. It would not pay for that. But what it was prepared to pay for was drugs to enable her to be euthanased. That was an option that it gave her. It was not the top option.

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I understand it was one of many options. But the option of giving her the appropriate drugs that would enable her to get better was not on the list. I worry that those sorts of situations may occur if this type of legislation is put in place. People talk about safeguards and not having any loopholes, and I will come to that in a moment, because I want to go through some of those questions.

On a personal level, I have a real difficulty with setting up a situation that will essentially provide for state-sanctioned suicide or assisted suicide. I have had people phone me or email me or write to me about this matter. I must say that on this occasion, I was very impressed with the level of detail that people put into their correspondence and with how articulate they were in their reasoning as to why we should not have this legislation. I must say that I could count on the fingers of one hand the number of people who sent in correspondence saying they did support this legislation. It is good to get that feedback. But I do not think this legislation is good legislation. I do not think it is good public policy to introduce this type of legislation.

I turn now to some of the issues that I have with this legislation. I hope that Hon Robin Chapple will respond in his reply to some of these issues. This bill refers to a "recognised drug". My 15-year-old daughter and I were talking about this issue at home the other night, and she said to me, "Mum, what drugs will they use to euthanase people? What drugs will they use to kill people? Will it be illegal drugs, or will it be drugs that are already available here? What drugs will it be?", and I said, "I do not know." So I would appreciate it if Hon Robin Chapple will tell me what drugs will be used, and whether they will be listed somewhere.

Hon Robin Chapple: That will be determined by the Medical Board.

Hon KATE DOUST: That is my next question. I had a quick look through the bill, and I could not find it. The member talked about how people will need to go through their doctor and go through a range of other steps. But will there be an overall body that will have oversight of this system and that will manage the process above the doctor? Will there be a body that will ensure that the checks and balances are there, and that all the paperwork has not only been complied with but has been stored somewhere? Will there be a body that will conduct a review from time to time?

Hon Robin Chapple: That is stated in the bill.

Hon KATE DOUST: I appreciate the member pointing that out to me, because I could not find a body that is named in the bill that will have oversight of this process, and that is of concern to me.

Clause 6, headed "Request", sets out the persons who can apply for euthanasia. Subclause (1)(c) states that the person must have been resident in Western Australia for the previous three consecutive years. Who will determine that? What will a person need to do to establish residency? This is an issue in other places in the world, such as Switzerland, that allow voluntary euthanasia and have a residency requirement. I am curious about what mechanism a person will need to use to demonstrate genuine residency in Western Australia and therefore be eligible to apply for euthanasia. Also, I found the definition of terminal illness to be quite vague. I have received a couple of letters from people who have debilitating conditions rather than terminal illnesses, and in their correspondence they described being depressed and wanting to terminate their lives. I worry that those people might think this is an opportunity for them.

Hon Robin Chapple: It's not.

Hon KATE DOUST: Also, in reference to the two-year period, quite often when people are diagnosed with a terminal illness it is short and sharp. Hon Robin Chapple's Voluntary Euthanasia Bill 2010 is not aimed at providing assistance to those people, and I would imagine that would be a greater pool of people than those with a longer term, drawn-out terminal illness.

Hon Robin Chapple: The two years is the upper mark; it does not have to be two years.

Hon KATE DOUST: Hon Robin Chapple can respond when he gets to his feet. I am just curious about how that could be managed, because I would imagine that that group of people, if they are not participating in palliative care or getting the necessary support, may be looking for a way out.

The other inconsistency that I wanted to pick up on was in clause 7, which relates to witnesses to the request. People have to be 21 years old and fulfil all the other criteria to be eligible to be an applicant, but clause 7 states that the witnesses can be two persons 18 years of age or over. I just wondered why they did not have to be 21 years old. If people have to be 21 years of age to be eligible —

Hon Robin Chapple: Three years' residence in Western Australia.

Hon KATE DOUST: Sorry?

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Hon Robin Chapple: They have to have been resident in Western Australia for three years, and three plus 18 makes 21.

Hon KATE DOUST: That is not stated in the bill.

Hon Robin Chapple: It is in another part.

Hon KATE DOUST: That is not stated as being part of the criteria for being a witness. It refers to that for eligibility, but I do not see anything in this clause that states that the witnesses have to have been living in WA for three years before they can be witnesses. If it is somewhere else in the bill, then I am happy for the member to show me. But I would have thought that if that is a requirement for being a witness, it should be clarified in that clause.

Hon Robin Chapple: It is not the witness; it is the applicant.

Hon KATE DOUST: No, but I am asking why there is an inconsistency in the age of the witness compared with that of the applicant, and the member is saying that the witness must also fulfil a residency requirement.

Hon Robin Chapple: No.

Hon KATE DOUST: My question is simply, then, why is there an inconsistency between being the age of 18 to be a witness, but people have to be 21 to be an applicant?

Hon Robin Chapple: It is all to do with the applicant, not the witness.

Hon KATE DOUST: Anyway, I would be interested to find out the reason for the difference in age; I think consistency would have been better.

My last question on this bill is about clause 11 on page 14, which relates to the administration of euthanasia. The clause states that an applicant's medical practitioner must remain with the relevant applicant until death has ensued. Thinking practically, if that was to happen in a hospital—I am thinking back to when my grandmother died and I stayed with her until it happened—doctors and nurses would be coming in and out all the time, and, under our public health system, they would not always be the same people. Given the shortage of doctors in a number of areas, particularly regional areas, if this bill was enacted how could we possibly expect one doctor to stay with one patient until that person died? Given that it will not happen—I do not know how long these things take.

Hon Robin Chapple: It's fairly instantaneous.

Hon KATE DOUST: Okay; I was not too sure about the time it would take, but I thank the member for that.

Those were some questions I had about the bill; the member may have answered some of them now, but hopefully he will answer some of them later. I suppose at the end of the day it does come down to what we believe. I have always taken a fairly clear position on issues relating to life. I suppose I am fairly traditional. I think we have to do whatever we can to preserve the sanctity of human life wherever it is on the continuum, be it pre-birth, post-birth or all the way through to the end of life. Given our current situation, we have a fairly good system that does try to make people as comfortable as possible. There are decent types of medication that provide good pain relief. We all want to have a good and pain-free death. When people talk about bills such as this and talk about wanting to take pain away and make it easier for people and say that they cannot bear to see people in pain, I sometimes sit back and wonder whose pain we want to take away. Do we want to take away the pain of the person who is ill and dying or do we want to take away our pain because we do not know how to deal with it well enough. For me that has always been an issue.

I know that a couple of other people want to speak. For me the position is fairly clear. I cannot support Hon Robin Chapple's bill. I know that he has probably put this out with what he believes to be good intentions. I do not believe it to be good public policy. I do not think that it sends a very good message. I think that in some ways it is an easy way out. We should be doing more to provide better services to people to make sure that they do have the best they can at that point in their lives. That is a real challenge for us. I hope that members in government who have the opportunity to engage in making those decisions take on board the views that have been expressed in this chamber in the past couple of days and will be proactive in that area. I think that it will be a plus for everyone in this state if we can do things better.

One final comment I might make is that I think that these types of debates are very healthy. We have been fortunate in some ways over the past few years to have had a range of these types of debates on very complex ethical, moral and legal issues. Members in our community probably in some ways look forward to these debates because we can act and speak our minds. I think we have all been through copious amounts of paperwork. Sometimes we just have to put that to one side and think about what our views are and how we have come to

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them. I say this as a member of the Labor Party. I think the community expects members of Parliament to express their own views more often or to be more reflective of individual parts of the community. I think that we will have more and more of these debates over time dealing with a diverse range of matters. We have seen that here in this chamber when we have dealt with stem cells, cloning, surrogacy, abortion and euthanasia a couple of times. I am sure that there will be more to come our way. I think that in some ways it better educates us as members and it actually gets us thinking about these issues. I think it also encourages the community to think about these issues, which is a good thing as well.

On this occasion I cannot bring myself to support a bill that would assist in taking a person's life before that person's time, so I will be opposing this bill.

HON SIMON O'BRIEN (South Metropolitan — Minister for Transport) [10.49 pm]: We are considering the Voluntary Euthanasia Bill 2010. I shall be opposing this bill. The progress of the bill is being followed by many observers. It is important that I take a moment to explain the reasons why I am opposing the bill so that it is clearly understood by those who are following the debate. I want observers who read the record of these proceedings to know that the matter is being debated in this chamber in a civilised manner; indeed, in a way that does great credit to the Legislative Council and its members. Proceedings have been conducted with respect for all the views represented in this place as we search, from our various viewpoints, for the right answers. As I have said before, before one can find the right answer, one has to know the right questions. The question that is before the house is that this bill be read a second time; that is, that the bill pass a crucial stage in the parliamentary process and a policy be adopted for further consideration. That is what that question means. This is not a debate about which particular point of view has a monopoly on decency, compassion or humanity, and for that reason it is to members' credit that these proceedings have been conducted in a way that respects the views of legislators who, one and all, are approaching this matter with the utmost seriousness and with all of the due consideration that such a grave matter merits. Members should have no doubt—this debate is about a matter of extreme gravity.

We in this house are legislators in our current role. Each of us has a responsibility to defend and protect the freedoms of the Western Australians who have elected us. Principal among those freedoms that we all enjoy is the right to our very lives. As legislators, to protect that right, we have to appreciate that every life has value. We also have to comprehend that if we adopt a policy that a life can be declared to be without value or worthless, or needs to be expunged, then we abandon that key part of our responsibility; we pass through what has been variously described as a portal, boundary or threshold that takes us into a different moral dimension that has real consequences that can be visited upon so many Western Australians who may think that they are not impacted upon by this legislation because it does not affect them today, or because they are somehow reassured that it will not apply to them unless they want it to. I need to assure all those listening to this debate that this is a matter for all Western Australians. It is a matter of extreme gravity, and it is being given appropriate weight, I am sure, in the minds of all members as we consider its merits.

The bill before us proposes that we enact a law for a system to enable people to be put to death, if they choose, in certain circumstances, and after the completion of an application process. As I say, it is a matter of extreme gravity. I have the great privilege of being not only a member of the Legislative Council, but also a minister of the Crown, and part of my portfolio is as Minister for Disability Services. I know, as other members know, that there are people in our community living with disabilities, some of them from birth and some of them for a very long period of time, either because they have a disability and need help in their day-to-day life, or they care for a person with high support needs, or they have acquired high support needs during the course of their life and have to live with that for a very long period of time. I am constantly impressed from my vantage point as that minister in the tenacity and the innate dignity of the human spirit to endure, despite the difficulties, pain, hard yards and indignities that humans can find themselves subject to at times in their life, sometimes for a very long time and sometimes imposing very great difficulties in carrying out the most routine and simple of daily tasks. Therefore, I understand the vulnerability of so many people in our community. I think collectively all members understand that there are more people with vulnerability in our community than people living with disability; there are others dealing with the frailty of being geriatric, of the uncertainties of health circumstances, of illness and so on. Each of these people is vulnerable.

In bringing my perspective to this debate and my view, which I hold very firmly, my attention was drawn to the words of Dr Erik Leipoldt, a resident of Wanneroo, who is a man who has lived with quadriplegia since 1978 after a diving accident. In his role as an author, Dr Leipoldt wrote something that I would like to put on the permanent record so that all who read it can take notice of what this person who knows what he is talking about has said —

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Government-mandated euthanasia is too dangerous for vulnerable people, in an uncaring society that already devalues them, for example because it abhors dependence, fragility and vulnerability. Instead we would be more constructively engaged by working towards excellent care in everything we do for others - ie, a caring society.

I do not know Dr Erik Leipoldt, but I identify closely with the sentiments that he expressed in those words. I want to reassure those observers of this debate who rely on having a Minister for Disability Services who understands their vulnerability that it is very much with my portfolio constituency in mind that I will oppose the principle in this bill. There is no need for me to turn to the provisions that are contained in the bill; the principle is fatally flawed in my view. Therefore, I will not turn my remarks to questions of whether the bill as constructed would work properly or whether it is flawed in some way or other. I hope not to because I hope that the Voluntary Euthanasia Bill will be defeated at its second reading vote in just a moment.

Therefore, I conclude with a thought that is not specific to consideration of this bill from the point of view of people with disability, but is something that should be understood by all who are involved in the process of being an elected representative and who have to consider matters such as this. I am indebted to the Most Reverend Roger Herft, the Archbishop of Perth, of the Anglican Church of Australia. I am sure that this could be considered an ecumenical matter, but I am officially a Catholic.

Hon Sue Ellery: He would be happy if you called him Roger; he is pretty relaxed about that sort of thing.

Hon SIMON O'BRIEN: I am indebted to his grace for the letter that he provided to all members back in February 2010. He enclosed a copy of some thoughts that had been penned by the Most Reverend and Right Honourable Dr Rowan Williams, Archbishop of Canterbury, in an address on 9 February this year in which he said, in part —

The freedom of one person to utilise in full consciousness a legal provision for assisted suicide brings with it a risk to the freedom of others not to be manipulated or harassed or simply demoralised when in a weakened condition. Once the possibility is there, it will not only be utilised by the smallish number of high-profile hard cases but will also create an ethical framework in which the worthwhileness of some lives is undermined by the legal expression of what feels like public impatience with protracted dying and 'unproductive' lives.

That is a very well framed summary of the question that confronts us in this place today. The answer to that question clearly must be to resolve the matter of the second reading in the negative; and, with the respect that has been shown to other speakers in the course of this debate, I offer that view to honourable members now and hope that they will indeed reject this bill.

HON ADELE FARINA (South West) [11.01 pm]: The debate on euthanasia faces members with two opposing sets of values: one that affirms an individual's right to make decisions concerning his or her own life and death in accordance with his or her own values and beliefs, as long as no harm is done to others; and one that denies this right and argues that euthanasia is contrary to God's law and the fundamental human right to life and is contrary to medical ethics.

Like all members of this place, I have received representations from constituents and from further afield on this issue, both in support of and in opposition to the bill. I found it interesting that, in contrast to the living wills bill debated in this place in 2007 and 2008, I have received fewer representations on this bill. I think this may reflect the greater community support for voluntary euthanasia legislation than previously existed. It is certainly reflected in conversations that I have had with constituents on the issue. It is also reflected in the poll results on voluntary euthanasia detailed by Hon Sue Ellery in her contribution to this debate. It must also be noted that those who oppose voluntary euthanasia are very strong in their opposition.

Our responsibility in this place is to represent the views of our electorate. However, as is often the case, the community does not speak with one voice, and we are required to consider all viewpoints, research the issue and ultimately be guided by our own values and the values of society broadly. Coming to a decision on how I will vote on this bill has caused me more conflict than I had anticipated, and it has caused me to give very careful and considered thought to the issue and in particular the bill.

The bill before us is a very restrictive bill. Many of the personal experiences of constituents who have made representations to me in support of a voluntary euthanasia bill will not in fact be covered by this bill. It concerns me that for those constituents supporting voluntary euthanasia, this bill will not deliver what they expect or believe the bill will deliver, in that the circumstances in which the bill allows for the administration of voluntary euthanasia are so restrictive that in many circumstances the right to choose when and how to die will still not be

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available to those people. People with Alzheimer's disease will not be covered by the bill. Cases like Christian Rossiter will not be covered by the bill. A person who wants to make advance provision to avail himself or herself of voluntary euthanasia in the event of certain circumstances will not be able to, under this bill. The only options that remain for some of these people are living wills and the prospect of slowly starving to death, which I do not think is a very dignified way to die.

The bill requires that a person must be of sound mind, aged 21 years or over, a resident of Western Australia, able to communicate his or her intentions, have a terminal illness, be experiencing pain, suffering or debilitation that is considerable and is related to the relevant terminal illness, expected to die within two years and the person has no desire to continue living. These requirements significantly restrict the instances in which voluntary euthanasia will be available under the bill. In addition, the applicant is required to sign the prescribed request form in the presence of two witnesses. The bill details who cannot act as a witness: the assessing medical practitioner, the authorised signatory; and near relatives of the applicant and an independent interpreter, if one is used, may not act as witnesses. The request must be assessed by a medical practitioner. There is no requirement on medical practitioners to undertake an assessment, so if euthanasia is against a medical practitioner's personal values, he or she is not obligated to participate in the process or to assist the request for voluntary euthanasia. A medical practitioner who agrees to undertake an assessment has a detailed list of matters he or she must satisfy themselves of as part of the assessment, and these are detailed in the bill. The medical practitioner must also inform the applicant of a list of matters that are, again, detailed in the bill, including diagnosis, prognosis, treatment options, counselling options, palliative care services, methods used to administer euthanasia and the risk associated with those methods, and the applicant's ability to revoke a request at any time. The assessment is undertaken by the applicant's medical practitioner and a second assessing medical practitioner. The assessment must be undertaken separately and independently of the other, and a list of matters that must be considered as part of the assessment are also detailed in the bill; and these are quite extensive. Assuming the medical practitioner and the assessing medical practitioner sign off on the request, the applicant, if he or she wishes to pursue euthanasia, must then make a second request on the prescribed form and no sooner than 14 days after the first request is made. Again, this request must be witnessed by two adults, and the same criterion applies as to who can act as a witness. In addition, at least one of the witnesses must not be a witness to the first request. Then, a third medical practitioner is required to observe the euthanasia process. The bill also restricts the administering of euthanasia to the applicant's medical practitioner.

This is a very onerous process, as it should be. However, it concerns me that in rural areas, where there is a shortage of doctors, meeting these requirements may be unduly onerous and it would concern me if the bill were enacted in its current form and rural people were disadvantaged compared with people living in the metropolitan area, simply because of a lack of access to doctors in rural areas and, in addition to that, a lack of access to doctors who might be willing to participate in the process. I understand why Hon Robin Chapple's bill provides these safeguards; however, I remain concerned about the implications of these safeguards for people living in rural areas. Finding three doctors may be a struggle at the best of times. Finding three doctors willing to participate in the process may be impossible in some rural areas.

There are other aspects of the bill that concern me. For example, clause 16 provides that —

A person ... who does anything required or permitted under this Act to or for an applicant forfeits any direct or indirect financial or other benefit (other than reasonable payment for services) that would otherwise have accrued or been vested in that person following the death of that applicant.

This means that a witness to a request for voluntary euthanasia cannot be a beneficiary under the applicant's will or, if that person is a beneficiary, he or she would then forfeit his or her beneficial interest under the will. I understand why this provision has been included in the bill to address, at least in part, the concern that a person may be unduly influenced to opt for voluntary euthanasia by a relative who would benefit financially from the person's passing. However, it is not clear to me how the executor of a will will be informed, or will be able to inform himself or herself, as to whether a beneficiary under the will falls within clause 16 of the bill and therefore will forfeit his or her entitlement under the bill. The liability that that may then impose on the executor of the will also concerns me, because the person will not be able to inform himself or herself of those circumstances. It concerns me that clause 16 provides that a person who does anything required or permitted under the legislation may receive reasonable payment for services. Although I understand that this exception is to provide for payment of medical practitioners, it concerns me that it may give rise to witnesses being paid for their services to act as witnesses. Given that relatives are excluded from acting as witnesses, payment of witnesses may well arise as a result of this issue and we may end up having professional witnesses. It also

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concerns me that, in an effort to safeguard against undue influence, family and relatives will be excluded from the process at a time when one may want to be surrounded and supported by family and friends.

I will address these concerns with the bill during the committee stage should we get to consider the bill in detail. I think a number of these issues can be addressed through amendments. As Hon Sue Ellery stated, this is an imperfect bill. The imperfections in the bill have given me cause for concern and have caused me to question whether I should support the bill.

Those who oppose voluntary euthanasia do so on the basis that we should not sanction the taking of another person's life, even if it is the wish of that person to end his or her life. Opponents argue that we are on a slippery slope when we legally permit medical practitioners to administer drugs that end life. This argument, however, ignores the current medical practice. Although the Australian Medical Association denies that medical practitioners administer drugs that end life, the truth is that some medical practitioners in certain circumstances do exactly that by the withdrawal of medical treatment with the patient's consent and/or the administering of a drug dosage that, although intended in the first instance to alleviate pain, results in death. The Minister for Health spoke on ABC radio this morning of his personal experience in this regard. He said that, as a medical practitioner, he had a patient who was dying and was in immense pain. He informed the patient and the patient's family that if he administered the standard dosage of painkiller, it was unlikely to provide pain relief because of the advanced state of the patient's medical condition and also because of the painkiller that had been provided up to that time. He explained that he could administer a higher dosage; however, a likely outcome of this increased dosage would be to hasten death. With the consent of the patient and the patient's family, he administered the higher dosage. I trust that I have adequately represented what the Minister for Health said on radio this morning. This is a situation that medical practitioners are frequently faced with, and frequently they take the same action taken by the Minister for Health in the case that he described. When the Minister for Health was questioned whether he had at that time administered euthanasia, the minister argued that he had not. He argued that his primary intention in administering the increased dosage was to relieve pain, not to hasten the death of the patient, even though he knew that this was a likely or probable outcome of administering a higher dosage.

The comments I am about to make are in no way a reflection on the Minister for Health. He is not alone in making the decision he made. Medical practitioners make the same decision every day. The Minister for Health, some other medical practitioners and even Archbishop Hickey make a distinction between administering a dosage of a drug with the intention to hasten death and administering a higher dosage of a drug with the intention in the first instance to alleviate pain, even if the result may hasten death. The former is unacceptable and the latter is acceptable. I find this distinction difficult to accept because in the latter case, although the intention in the first instance may be to alleviate the pain, the medical practitioner nevertheless also knows that it is probable, likely or highly likely that death will result. I struggle with this distinction. I find the distinction that is being made to be a distinction of convenience. As I said, I do not say this to be critical of the Minister for Health or other medical practitioners who make this distinction and who have made similar decisions to that made by the Minister for Health when he was a medical practitioner. I am sure that the patients and the families of the patients are grateful to them for their compassion. I know that I would be in the circumstances. My point is that if it is acceptable for a person to decide to deny themselves the necessities of life by refusing food and drink, and if it is acceptable for a medical practitioner to stand by while this is happening knowing that the person will starve to death, and also if it is acceptable for a person to decide to have a higher dosage of a drug administered and for a medical practitioner to administer a higher dosage of a drug with the intention in the first instance to alleviate pain but also knowing that it will result in death, how much of a step is it to recognise this in legislation to protect medical practitioners from criminal and/or civil liability?

The truth is that the practice of euthanasia is already happening. It is happening in secret and we are choosing to turn a blind eye to it. That may be well and good, but it is a legal case waiting to happen. I wonder what the Minister for Health would have done when he was a medical practitioner and was faced with this dilemma. If he had explained this option to the patient and the patient's family, and the patient had consented to the administration of a higher dosage and all but one member of the patient's family had consented, would he have administered the higher dosage, giving greater weight to the wishes of his patient as opposed to the wishes of one objecting family member? Should he and other medical practitioners be put in the position of having to make this decision without legal protection from criminal and/or civil liability? Should the right of the patient to decide to have a higher dosage administered be ignored by a medical practitioner because one family member takes objection to this, despite the patient's wishes, and because the medical practitioner is concerned about a possible criminal or civil prosecution if he or she were to administer the higher dosage in accordance with the express wishes of the patient?

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I expressed my struggle with the distinction that has been made in my reply to Archbishop Hickey's letter on this issue, which I am sure all members have received. Archbishop Hickey argued that withdrawing treatment, even when the treatment is to sustain life, if the patient so chooses, is acceptable and is not euthanasia. He argued that this is a patient's legal and moral right. He further argued that the use of medication to ease severe pain, even if it shortens life, is acceptable as a legitimate medical practice because death is foreseen but is not intended. It is my view that in those circumstances death is reasonably foreseeable. If it is unacceptable to bring about a person's death, then these actions—the withdrawal of treatment, the refusal to provide the necessities of life and the administering of higher dosages, knowing that they will or are likely to result in death—should not be acceptable as they all result in death and the medical practitioner knows this to be the case.

If it is a personal, moral and legal right to consent to any of these actions—the withdrawal of treatment, the refusal of the necessities of life and administering a higher dosage of a drug to relieve pain that is also likely to result in death—I believe that the right to consent to voluntary euthanasia is an extension of this personal moral right and should be protected by law. Provided that self-determination does not harm another person, I do not accept the argument that self-determination should be permissible in certain circumstances but not in others. There is no dignity in being forced to die a slow and painful death, during which time one loses bodily functions and all dignity and loses the capacity to enjoy life and live life how one wants to live and to exist with no quality of life. There is no dignity in starving oneself to death in order to choose when one dies and to lessen one's suffering. There is no dignity in committing suicide and dying alone in order to be able to choose when one dies.

As I said, I have struggled to come to the decision I have tonight on this bill. In summing up, the bill does not make euthanasia compulsory; it is voluntary. The bill does not require or force medical practitioners to participate in the assessment of a request for voluntary euthanasia or in the administering of euthanasia. The bill does not force people who do not support euthanasia to take this option. People who want to continue with medical treatment to the very end will not be impacted by the bill. People who wish to leave it to doctors and others to make decisions whether to increase drugs to relieve pain and also hasten death will not be impacted by this bill. This is already happening and there is no reason why it would not continue with the passage of the bill. The bill, however, will protect people who are terminally ill and satisfy all the extensive requirements in the bill in making a decision as to when and how they will die.

Even though I have concerns about the bill, if I were diagnosed with a terminal illness and I went through a period of up to two years of excruciating pain and illness and no quality of life, I would want the right to decide whether I wanted to avail myself of voluntary euthanasia. I do not know whether I would ultimately exercise this right—none of us can be certain of this—but I would like to have the right to exercise that choice. The bill also protects those who assist with the euthanasia process as detailed in the bill, a protection that the law should afford in the circumstances set out in the bill. While the bill is imperfect, I believe that we can address many of these imperfections in committee through amendments. The bill is very restrictive in its application and in some circumstances the safeguards may well be onerous. However, on balance, I am persuaded to support the right of a person to choose the manner and time they die with some dignity. I do not believe I have the right to impose my views and values on others. Provided no harm is done to others, I believe we as legislators should legislate to enable an individual to make decisions concerning his or her life and death in accordance with his or her values and beliefs. This bill facilitates self-determination, albeit in a limited way. After much consideration, I will be supporting the bill.

Before I conclude, I want to make a brief comment on palliative care. Like other members, I do not believe that palliative care and voluntary euthanasia are mutually exclusive. I also add my support for more funding to be directed to palliative care. I am proud to say that in Busselton we have the Busselton Hospice, which was built and funded by the Busselton community. It has very strong community support and the support of local GPs as well as a great team of volunteers who provide the service and work at the hospice, and through that provide an opportunity for those people living in Busselton and in need of palliative care to die with some dignity. I am very proud that we have this service in Busselton, albeit that it could do with a great extension to cater for more people, as I am sure is the case right across the state. That is the reason I support more funding for palliative care.

HON ROBIN CHAPPLE (Mining and Pastoral) [11.25 pm] — in reply: This is one of the few occasions on which, in a reply, one must address so many people, so I will try to truncate my reply. I will start with Hon Nick Goiran. As we run through the responses to people, we will probably hear less comment because I will have dealt with matters. I want to thank members for their contributions. This has been a significant debate for people. In most cases it has been a debate about conscience. I thank also the Leader of the House, Hon Norman Moore, for providing the time for this debate. This is the first time in this chamber we have had this debate and it has gone to its conclusion. I think the calibre of the debate has been astounding. If we could have this level of debate

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on every matter it would be rather good. It has been respectful, frank, personal and, in some cases, philosophical. That is perhaps the point we have skirted around a little bit. Some speakers have been up-front with a philosophy. Others have dealt with the core of the bill or the clauses, which would have been more appropriately dealt with in the Committee of the Whole. Having said that, because we have dealt with a lot of the clauses, I have a lot to deal with in my response.

I noted the important point that the Leader of the Opposition raised when she talked about the 36 members of this chamber having to deal with something that is widely accepted by the community, but the community itself does not have to struggle with the depth of the debate we are dealing with here now. That was a really important point to make. It is important that members recognise when dealing with all forms of legislation that we are 36 people in this chamber who have to make deliberations for a wide range of people.

I commenced engagement on this issue with members in this place in September 2009 when I wrote to all members. Since then we have noticed that lobbying has ranged from heartfelt, sincere, bizarre, informed and, in my case, sometimes scary. When we have dealt with matters of lobbying, it is quite fascinating that, whilst the last national Newspoll in October 2009 referred to Western Australia as showing the highest support for voluntary euthanasia—86.3 per cent of WA metropolitan, and 92.1 per cent of WA country—the lobbying we have received in fact has been almost the reverse of that. I think that was touched on by Hon Philip Gardiner. Some members have talked about things in the bill that need to be amended, yet I notice there is nothing on the notice paper. Have we already concluded we will not get to what I consider the important part of this debate, the Committee of the Whole, when, indeed, I made it very clear to many in the chamber that I was amenable to a number of amendments, should the house wish so.

In the broader public debate, sometimes this has been referred to as a Greens' bill. I am a member of the Greens, but it is not Greens policy; it has not been established by the Greens or supported by the Greens in the broader concept of the party. We have no policy on this matter whatsoever. I thought it was important to clarify that.

As I said, I will spend a fair bit of time dealing with Hon Nick Goiran's issues because they touch on many of the issues raised by other members. I hope to mention every member who has spoken tonight. With a bit of luck, we should be out of here at some stage tomorrow. I appreciate that all members, regardless of how they vote, are motivated by a sense of compassion for people in difficult health circumstances. We touched on palliative care and many other things. That was the important point from the very outset that Hon Nick Goiran raised. It was disappointing that the member asserted that there are a great many arguments against euthanasia, without attesting to the fact that there are mostly a great many arguments for euthanasia. But, understanding where the member comes from, I can understand that that is his viewpoint.

It is interesting that the first speech ended up being a legal comment rather than a philosophical comment. Most probably that is because in Hon Nick Goiran's former profession he was a lawyer. He seems to have been given a brief as a lawyer, and he has simply argued that side of the case. He made the statement that it is a legal impossibility to protect against involuntary euthanasia when voluntary euthanasia is legalised. If what the member means by that is euthanasia without explicit consent, then he must know that that is already happening in Australia. As we have attested to today, the Minister for Health has already acknowledged that activity. In 1997, if we are talking about law, Kuhse et al published their survey of Australian end-of-life decisions. That is the only Australian study comparable with the Dutch Rummelink studies. From this survey of 1 918 Australian doctors, they estimated that 1.8 per cent of all Australian deaths were by voluntary euthanasia or physician-assisted suicide, which is happening without regulation; in 3.5 per cent of deaths, there was termination of the patient's life without explicit request—five times higher than the rate in the Netherlands, the place that is argued by some as being an example of the slippery slope; in 24.7 per cent of deaths, treatment was withheld or withdrawn with the intention of hastening death; and in 6.5 per cent of deaths, opiates were administered with at least the partial intention of hastening death. That is an Australian study of practices that are already in existence in this nation. The full citation of this study is Kuhse, H, Singer, P, Baume, P, Clark, M and Rickard, M, "End-of-life decisions in Australian medical practice", *Medical J Aust*, 1997, Vol 166, 191–196. I have a copy of that document, and I seek leave to table it.

Leave granted. [See paper 2532.]

Hon ROBIN CHAPPLE: Thank you, Mr President.

I want to give members a few more thoughts about what Hon Nick Goiran had to say. This was, indeed, touched on by other members. Hon Nick Goiran asked: what will happen if the doctor gets it wrong? In saying that, is the member saying that doctors do not make mistakes now? Of course he is not. He himself has acted in medical negligence cases. So, how do we make the prospect of mistakes negligible? I would suggest that we have done

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that in this bill. By providing multiple criteria to be addressed, and by providing multiple doctors who are to turn their minds to those criteria, I would suggest that this bill does that. Hon Nick Goiran gave the example of a person who it appeared would soon die but thankfully did not. The process of this bill will probably take months. There will be at least two weeks between the first request and the second request. At the second request stage, the person must be seen by the two medical practitioners again to see whether the person is still terminally ill and still wants to progress with the application. So, that example would not apply, because of the periods of time between the assessments, and the right of the patient to withdraw from the request at any time. There are thousands of deaths in Western Australia every year, and there are hundreds of others for whom the pain and indignity is too great now, all of whom are going to die. We can always deal with stories in isolation, but I would attest that the vast majority of people greatly support having the ability to choose an option about when and where they wish to die at the end of their lives.

The member also questioned whether someone who is dying is competent to express their views. This catch 22 argument is often put up by opponents to voluntary euthanasia, but it is totally flawed. If what a dying patient says cannot be believed, how do palliative care practitioners satisfy patients' end-of-life wishes, which is what happens now? They can and they do, and I will quote from a letter I received recently from Hon Clive Deverall, AM, the former chair of Palliative Care WA and the former chair of the Cancer Council of Australia. The letter reads —

Dear Robin,

Well done on taking the initiative to have another go in developing legislation to accommodate euthanasia within our health system.

Having been the Chair of Palliative Care WA for many years and having helped develop most of the structured palliative care services in WA since the late 70s I now find myself an enthusiastic supporter for what you are trying to do. I have attached some of the issues which have convinced me that support for euthanasia, regionally or nationally, is the way to go.

Good luck.

Clive Deverall AM Hon.D.Litt (Curtin)

I think that letter debunks some of the views we have heard about voluntary euthanasia not being supported by palliative care. As I said to Hon Michael Mischin, I have attended a number of palliative care functions and I have spoken with the palliative care executive, and I did not get the message that has been espoused around the chamber. I have gone out and spent a lot of time talking to people.

Hon Nick Goiran also raised concerns about the vulnerable. It is quite odd to suggest that I, or the Greens (WA), are not concerned about the vulnerable. I have been more than satisfied with the evidence from jurisdictions where voluntary euthanasia is lawful on this point. One key study is entitled "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable groups" was featured in *J Med Ethics* 2007; 33:591–597. I seek to table that document.

Leave granted. [See paper 2533.]

Hon ROBIN CHAPPLE: This is a quote from that detailed review of past evidence —

Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups.

That seems to be a forward-taking statement, but it was based on the reviews of all patients who had used voluntary euthanasia and who were covered in that study. That document was produced in 2007.

A number of people, including the member, have used all sorts of "slippery slope" arguments that are common in this area. Oregon is sometimes cited in these arguments, but the Oregon example should actually allay concerns. Formal reports to the legislature in Oregon each year, under its act that came into effect in 1997, clearly and unambiguously show that there has been no avalanche of requests. Requests that have passed the rigorous process to gain assistance for the provision of a drug are modest in number—460 over 12 years. In 2009, 95 lethal prescriptions were written but only 59 patients made use of the legislation. I just want to touch on that. There is a value to many patients in having what we refer to as a security blanket. It is about being able to have available to them the option if things get too bad. We found that in a number of places where people have expressed severe concern and, indeed, some panic about the end of life and have then received the ability for medication and/or indeed the ability to go through a physician-assisted process, they then have not used it because their fears were alleviated. It is therefore actually having a positive impact on palliative care. It means that people can actually go through the process and die a natural death without that fear.

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It was interesting that the lawyer opposite attempted to use a technique that I am told is called “prior inconsistent statements”, specifically regarding an article that appeared in the *WAVES News* of February 2010, but there was no prior inconsistent statement. I was speaking to a group that wants a broader bill than I delivered to them, and acknowledged with them that for me the bill is as far as it should go. The West Australian Voluntary Euthanasia Society quite clearly wanted another outcome. My statement was, and I will read it again —

I realise this is a very restrictive Bill. However, it was my intention to draft a restrictive Bill. This is because a restrictive law has the best chance of being passed by the current Western Australian Parliament. I know many readers will be disappointed that this Bill does not go further, does not apply to more people and does not allow for administration of euthanasia by a person other than a medical practitioner. But this law is a good start, and a step in the right direction.

Those are the words I was relaying to a group of people who wanted more than I would give them. Hon Nick Goiran quoted concerns of just two individual practitioners about the suggestion that voluntary euthanasia adversely affected palliative care. I think that Hon Linda Savage addressed those arguments comprehensively and I mostly do not need to repeat what Hon Linda Savage had to say on this matter. As was expected, the member quoted the infamous seven deaths study. I am surprised that the member has tabled it, because he should read it in full. The two real authors of the study admit to carrying bias in their work. The conclusions reached fly in the face of the incredible suffering actually detailed in the same report. Yes, Philip Nitschke was listed as co-author, but he has subsequently repeatedly distanced himself from it and said that he was set up by the actual authors. Marshall Perron, who came to this chamber, the architect of the Northern Territory laws referred to by Hon Sue Ellery, said to me recently, according to my notes —

The living relatives of three of the seven that I know believe that the Kissane is a preposterous misrepresentation of the living hell their loved ones endured until death. They were certainly in a better position to know than the two academics examining paperwork years later from a distance.

Having mentioned Dr Nitschke, let me make it clear, as I have in other forums, particularly with the Executive Committee of Palliative Care Western Australia, this is not a Nitschke bill; it goes nowhere near far enough for him. I think Dr Nitschke and Exit International go too far in this area. I have always made it clear that I respect his views, of course, but that my views are far more conservative and realistic.

I want to thank Hon Nick Goiran for agreeing that palliative care assists only the majority of the terminally ill, not all of them. On the matter of improving palliative care and increasing funding for it, we are in furious agreement; but what of those who remain? People in the palliative care sector say that six per cent of terminal cancer cases cannot be addressed by palliative care. My public statements to date have been conservative, saying that only two per cent of terminal cancer cases cannot be addressed by palliative care. I need to make it clear: if members vote against this bill at this second reading stage, they are voting for the status quo, which is a situation in which even high quality and universally accessible palliative care is not enough.

Moving on to other members, I really appreciated Hon Ljiljanna Ravlich’s honesty. The member was particularly upfront about her Catholicism and raised concerns having regard to my five arguments in the second reading speech. I was really moved by her story about her friend who did not want to burden others. I am sure the member knows that I specifically address such situations in this bill, and I do not want anyone to qualify, under this bill, if they feel that they are a burden. Hon Ljiljanna Ravlich referred to her concerns about patients possibly changing their mind. We have addressed this concern as well as is possible. If members think that there is some new safeguard, we can add it while we are still giving all the options to the terminally ill. I hope that if we get to the committee stage we can consider such options. My concern is that, for every example of someone changing their mind, there are so many more examples of people dying while consistently calling for their pain and suffering to end. Hon Ljiljanna Ravlich also referred to Sir Edward “Weary” Dunlop, the Australian army surgeon on the Burma railway, who said that the most beautiful deaths he had ever experienced happened there, amid the brutality, pain, filth and degradation, because they were surrounded by mates who were there for them. I agree; what better way to ensure that the terminally ill person can determine the exact time of his death, and who will be with him to comfort him when that happens? Hon Ljiljanna Ravlich also referred to the opposition by the Australian Medical Association. I am, of course, aware of the AMA’s opposition to voluntary euthanasia, but I have seen the results of eight peer-reviewed surveys of doctors between 1987 and 2007, which revealed two key things: a diversity of practice in the profession itself; and very strong, sometimes majority, support for the legalisation of voluntary euthanasia. On Tuesday I emailed members with a document that included references to those various studies.

I very strongly, but respectfully, disagree with Hon Liz Behjat’s view that this legislation is the thin end of the wedge and the slippery slope; I addressed that matter in response to Hon Nick Goiran. Again, on Tuesday I

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emailed members with a more detailed response to such allegations. Hon Liz Behjat refers to some of the criteria in the bill as arbitrary. The majority of the public supports voluntary euthanasia with strict safeguards; I think that even most opponents of the bill would agree with that. That means decisions must be made about who is in and who is out. This bill suggests limitations to access, and I make no apologies for that. Had members given feedback at any time during the past year to suggest different limitations, I would have looked at them. We carefully considered over two months various overseas examples of legislation and various other bills. I think that the Voluntary Euthanasia Bill 2010 is best practice and is in no way arbitrary. If the member looks at any of the other legislation, this bill sets a parameter that I suggest needs to be envied by any other legislative arrangement that exists in the world.

Hon Liz Behjat: I did not say it was arbitrary, I asked who would be the arbiter; it is a different thing.

Hon ROBIN CHAPPLE: I apologise if that was the case. I will come to the matter of the arbiter in a minute. I will deal with that issue in response to a question asked by Hon Kate Doust.

One more comment needs a separate response, though. I have no idea how many letters the honourable member received in support of the bill, but I am surprised that she got none of the various letters from Christians Supporting Choice for Voluntary Euthanasia. Each of those letters was signed by hundreds of people, including dozens of Western Australians. I think the member said that she received just four letters in support of the bill.

Finally, the honourable member referred to Monday's *Q&A* program on the ABC, which discussed euthanasia. The member quoted the editor of *The Australian Women's Weekly*, but the better quote on the night, in my view, was from another panel member, Leslie Cannold, who was described as an ethicist and author. I will paraphrase what she said: we can either pass a law that impedes choice, or pass a law where everyone has a choice and where each of us can do what we believe is right.

Hon Sue Ellery then spoke; I commend Hon Sue Ellery for her contribution. It tested the way we should do things in this place. The honourable member talked about the notion of us being 36 members who during this process have gone into deep and meaningful deliberation. Notwithstanding my position, I really do thank members because it has been an honest debate, in my view.

In order to keep this debate to a reasonable time, I will not address all the points raised by Hon Brian Ellis because I will touch on some of those later and I think I might have touched on some already. However, he has obviously been engaged with this bill since last year and I thank him for that and I really appreciated his feedback. As he said in his contribution, some of the issues he raised have indeed been changed in the bill as it has progressed. This is the sort of dialogue that I hoped I would get from a lot of people. We made these amendments, in some cases just because Hon Brian Ellis raised them. In more recent times the honourable member has raised additional concerns and sought additional clarity. I thought that some of those things would have been addressed in the explanatory memorandum we issued last week. If this bill advances to the committee stage, I am prepared to either have the member move amendments on some of those issues or I will. In particular, I think the idea of referring to the availability of counselling for those involved in ending suffering is a good one.

I thank Hon Linda Savage for her support. I know it was a bit rushed and that she had to jump to her feet very early and did not have her notes in the chamber. I apologise for that. I thank the honourable member for her passionate commitment to the issues and for her published articles and presented papers in this area.

Hon Mia Davies then spoke and I think she largely raised concerns in her contribution that I have already addressed in my responses to other members. I thank the member for explicitly acknowledging that I consulted widely with my colleagues in Parliament and the wider community. There has been some media reporting in recent days questioning the extent to which I have made myself aware of the different options on this topic, especially within the medical profession. I went into more detail on this point in my response to Hon Ljiljana Ravlich's contribution. I want to comment on the following remark made by Hon Mia Davies —

It is flippant to say that the decision will not impact on anyone else. It has far-reaching ramifications for all involved.

I assure the member that I had no intention of being flippant. Perhaps, in retrospect, my choice of words in the second reading speech was less than ideal. The point I was seeking to make was simply this: patient autonomy is the key. It is all about the patient; it is not about the doctor; it is not about the relatives; it is all about the patient. The common law already acknowledges that laws passed by this Parliament for living wills recognise that. We simply say that this is the logical conclusion, and move to recognise patient autonomy.

Hon Michael Mischin; Hon Dr Sally Talbot; Hon Col Holt; Hon Lynn MacLaren; Hon Ken Baston; Hon Ed Dermer; Hon Ken Travers; Hon Helen Morton; Hon Max Trenorden; Hon Matt Benson-Lidholm; Hon Kate Doust; Hon Simon O'Brien; Hon Adele Farina; Hon Robin Chapple

The briefing paper that I believe was provided to all members of Parliament from FamilyVoice Australia perhaps states the point more eloquently than I have as follows —

Once society authorises physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist for them to deny this right.

The point I am making here is that my bill does not allow for that. That was a complete and utter furphy put out by FamilyVoice Australia. Any reasonable reading of the bill would show that is not the case.

Finally, Hon Mia Davies said —

There is a vast difference between supporting a theory or an idea and legislating for it.

I am concerned by this sort of argument. The member may not have meant it but I am concerned that this amounts to saying, “The reality of death is too hard to legislate for, so we won’t.” That amounts to saying that the status quo is acceptable. I have already argued that the status quo involves those life and death decisions happening anyway, but without laws and without transparency. I will touch on that a little later in response to another member.

I thank my colleague Hon Giz Watson, who again jumped to her feet to speak at very short notice in support of the bill. I also appreciate her support for my proposition that when doctors have been asked these questions in confidence, they come up with diverse responses and in no way just a response in line with the formal position of the Australian Medical Association. I also appreciate the note from my colleague that the majority of doctors are not members of the AMA. I also strongly support her when she spoke about the double-effect dosage. I suggest that this is the approach that is ethically indistinguishable from formal voluntary euthanasia; again, I will touch on that in a little while. The double-effect dosage is something that is firmly acknowledged by the medical profession.

I also read with great interest the piece in *The West Australian* on Tuesday by Ajahn Brahm, the abbot of Bodhinyana Monastery. I congratulate the abbot for weighing into the debate.

Finally, I want to acknowledge Hon Giz Watson for flagging an area for consideration at the committee stage, should the bill get to that stage. I thank her for her support now and at the second reading stage.

I welcome the views of Hon Alison Xamon and start by thanking her for this comment —

I am aware that medical practitioners are currently in effect undertaking a form of voluntary euthanasia. That is something that we do know is occurring and it seems to me strange that people seem to want to somehow turn a blind eye to this practice, which effectively leaves our medical practitioners, in my opinion, very vulnerable to the vagaries of the law and the state in terms of whether it does decide to take action.

I also thank Hon Alison Xamon, who put it very well when she said that because it is a private matter, we do need to structure some sort of regulation, law and parameters around this matter because she, for one, does not have confidence that the state will respect that this is ultimately a private matter. I also think we must acknowledge that Hon Alison Xamon was treated with some pretty poor quality lobbying during this process because of her religious position, and that was of concern to me. I thank the member for reading in the views of the Uniting Church, and I am appreciative that it decided to issue a statement in the lead-up to this debate.

Hon Jon Ford referred to funding of palliative care to a suitable level prior to having a debate on VE. It needs to be noted that I agree with Hon Jon Ford’s observation that if anything comes out of this, it should be greater focus on palliative care funding and research. As somebody who has attended a number of palliative care functions, they are in dire need—they really are! It is only by their pure guts in many ways that they are continuing to do a lot of the work that they are doing. I attended a national conference or function about six months ago, and it was quite devastating to hear the difficulties that organisation is facing in providing services around this great state of ours.

What struck me most about the situation in Oregon was that its state palliative care organisations strongly opposed euthanasia as it was being proposed; however, after three years, they changed their minds and policy and now work well with the provisions of euthanasia in that state. Holland has had the same example, and most striking of all, with fewer than four per cent of those eligible to access euthanasia, research reveals what a comfort it has been to those patients who ultimately do not take that option. That was palliative care making that statement; it has seen the benefit of that security blanket.

Extract from Hansard

[COUNCIL - Wednesday, 22 September 2010]

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Hon Michael Mischin; Hon Dr Sally Talbot; Hon Col Holt; Hon Lynn MacLaren; Hon Ken Baston; Hon Ed Dermer; Hon Ken Travers; Hon Helen Morton; Hon Max Trenorden; Hon Matt Benson-Lidholm; Hon Kate Doust; Hon Simon O'Brien; Hon Adele Farina; Hon Robin Chapple

Palliative care has been enhanced in many places where voluntary euthanasia has been legalised: the Netherlands, Belgium and Oregon, for example. Hospice care in Oregon is rated as one of the best in the USA, and physicians in Oregon have attributed this to increasing knowledge in palliative care. More than any other state in the US, Oregonians suffering from terminal illnesses are dying in the comfort and security of their own homes, with the aid of hospice care. That again is reflected in a paper titled "Oregon's Low In-Hospital Death Rates: What Determines Where People Die and Satisfaction with Decisions on Place of Death?" published in the *Annals of Internal Medicine*, April 1999. I agree with Hon Jon Ford that western nations already decide on life and death anyway by funding, failing to fund or not more fully funding, access to drugs that will greatly extend lives and that will eliminate disease. I thank the member for his passionate support of the idea that the status quo in this area must not be allowed to remain.

I have received a number of submissions on the type of morphine that is currently being used in end-of-life situations. Apparently there is a far better morphine derivative that is used everywhere else in the world but which is not allowed to be used in Western Australia. I thank Hon Jon Ford for talking openly about his incredible issues with pain management, and even briefly contemplating suicide. I was really taken aback by his story. I appreciate Hon Jon Ford's relating to us his experience that in some cases in their commitment to prolong life, death is not delayed for long, but additional pain is caused. Ultimately, I thank the member for supporting the second reading, even though he expressed serious reservations about supporting the bill after it is considered clause by clause, if we ever get to that stage.

Hon Helen Bullock said that Parliament has no right to introduce a bill to kill people. I think that every jurisdiction in the world has dealt with capital punishment at one stage or another. I felt that that comment was completely misguided. This is a compassionate bill to assist people who are dying and to enable them to die with dignity. This is not a "kill bill".

Hon Philip Gardiner talked about the issues of suicide not being illegal. That is an interesting point. Unfortunately, with the advent of Philip Nitschke and people's access to other forms of medications and other systems, we are finding that a large number of people are committing suicide but without their loved ones around them. They leave obscure notes such as, "Please, daughter, pop round in a couple of days", but when the daughter goes there, she finds a relative with an exit bag over his head. The trauma and pain of those processes are incredible, and they are growing exponentially. I do not like it. I think it is obscene. Unfortunately, until we bring in a form of legislation, those practices will increase. Statistical evidence from suicides shows that it is becoming almost an epidemic.

Hon Helen Morton: Are you talking about terminally ill people?

Hon ROBIN CHAPPLE: I do not know.

Hon Helen Morton: But the bill isn't going to cover people who aren't terminally ill.

Hon ROBIN CHAPPLE: The problem is that Mr Nitschke is promoting the fact that anybody can use his processes for whatever reason.

Hon Liz Behjat: If your bill got through, those who aren't terminally ill would still be using his processes, so move on.

Hon ROBIN CHAPPLE: But a lot of people who are terminally ill use these processes. I do not think it is fair on relatives and friends to be faced with those sorts of situations. In my view, a better process is needed.

Hon Philip Gardiner brought into the debate the issue of human biology. As somebody who follows biology, I found that very interesting. He dealt with the fundamental freedom of choice and the need for these new freedoms, which I believe are consistent in this bill. I loved his statement that our future is beyond our vision but not beyond our control. That was a marvellous statement. I agree with the member's assessment that surveys show that there is clearly a mood for change. I appreciate Hon Philip Gardiner's comment to the effect that, at the end of the day, VE should be one of those options. I support the member's observation that a person who is suffering should be given the credit and ability to decide his response to that suffering for himself and not be dictated to by others. I agree with Hon Philip Gardiner's comment that it seems that people are okay with freedom when it comes to economics, but not freedom when it comes to their own lives. I appreciate the member's observation regarding palliative care; it is not either/or. I think the letter from the former head of Palliative Care WA attests to that view. The observations from Oregon and other places show they are now mutually compatible. Finally, I thank Hon Philip Gardiner for his assessment of the bill that the risks are so low that they might be non-existent, especially when one considers the benefits for the sufferers.

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Hon Michael Mischin touched on the issues of scrutiny in this chamber, as Hon Sue Ellery already attested to. He was concerned that there was no cooling-off period, that no psychiatric report is required and also with the provision that a patient must be diagnosed with a terminal illness from which the patient is likely to die within two years. I will deal with those concerns individually. The member said that he had considerable sympathy for the objectives of the bill, but his tone changed as he spoke. Dealing with the issue of a psychiatric report, a doctor, as in any other medical practice, must be assured of the person's psychological state. If the doctor is concerned about the patient's psychological state, either the doctor does not proceed, which is a requirement of the bill, or the doctor refers the patient to a psychiatrist to deal with that matter. The reason for the provision that a patient must be diagnosed with a terminal illness in which the patient has two years to live is, to a degree, subjective. Some medical processes state that doctors can give certain medications only if the patient is deemed to be terminally ill and death will result within five years. That is already contained within medical legislation. We thought that five years was too long because it is difficult to attest to five years. Doctors who have actively involved themselves in double-effect dosages or who have gone a stage further indicated that two years is about the limit at which they can say that someone is terminally ill. If a doctor cannot diagnose someone as terminally ill, the provision does not apply. Unless the person is terminally ill and is likely to die within a two-year time frame, it does not apply. If a doctor assesses that a patient is terminally ill and is likely to die within five months, the legislation would apply to the patient. Two years is the outer limit. That was based on the judgement and evidence from doctors.

I have had kidney stones on a number of occasions and I have been told that it is a level-10 pain threshold equivalent to childbirth. My sympathy goes out to the ladies here who have given birth. I know what they have been through, and it is pretty horrible. The level-10 pain threshold is the highest level of pain, according to the medical professionals. They make those judgements about the level of pain based on known parameters. Doctors already make those decisions when testing the levels of pain.

In essence, Hon Michael Mischin also said that palliative care has advanced considerably in the past five years and that many members who support the bill referred to events of some time ago. I presume that was a reference to my mother. My mother was extremely well looked after. She was in a particular ward in a hospital that was fully equipped and that dealt with her pain. My mother was fully compos mentis during the process. She was very well looked after medically but was dying. That was my experience then. I am an older person, and we older people regularly tend to be around people that we know who are dying. A number of my colleagues recently have died from cancer and those sorts of things. It does not matter what level of palliative care there is because, as has been identified by people who provide palliative care, in a lot of cases pain cannot be managed. If we get to the committee stage, I would more than welcome an amendment by the member addressing his concerns about psychiatric assessment.

It was also mentioned that the bill had no cooling-off period. A specific cooling-off period is written into the bill; that is, 14 days between the principal or first request and the second or final request. The patient can immediately call a halt to the process at any time and the process stops in its entirety. Any patient wishing to continue cannot go back and stop the clock; he or she has to start all over again. There is definitely a cooling-off period, and the patient has the ability to opt out of the process that he or she initiated at any time.

I think I dealt with a quote from WAVES earlier. I will not continue too much more on that.

Hon Michael Mischin: Well, actually there is that bit about what you meant by administration by someone other than a medical practitioner.

Hon ROBIN CHAPPLE: I dealt with that. I do not think the member was in the chamber at the time. I will go back and do it again. Does anyone mind if I do it again?

Several members interjected.

Hon ROBIN CHAPPLE: I dealt with it.

I thank Hon Sally Talbot again for her support. It was really interesting that Hon Sally Talbot dealt with the philosophy of the bill. We kept skirting around what should have been discussed in the committee stage—that is, what the clauses did and did not do and possible amendments—whereas only a few people put their hand over their heart and said what the philosophy meant to them. That was an important point made by Hon Sally Talbot. She outlined quite systematically what the bill was not about. The bill is not about non-voluntary euthanasia. The bill is not about passive euthanasia. The bill is not about children. The bill is not about people in a coma. The bill is not about people who are not dying. Considering the critical issues, how do we phrase the question we are addressing considering this is from the point of view of philosophy? It was interesting to note that Hon Sally Talbot touched on the point that members toured the hospice in which the patients had chosen palliative care as

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there was no other option. Did the members who toured that hospice question whether those patients would be willing to seek voluntary euthanasia or had sought voluntary euthanasia? There is deathly silence.

Hon Colin Holt asked whether we have the right to ask someone else to end our life. He said he would be very interested to hear from me about that. I am not quite sure what he wants to hear from me. I believe that in cases in which people are dying, we should have the ability to respect their wishes and the way they choose their final moments. In my view, it is not about how we kill people or whatever else; it is about what those people want.

There has also been some concern about us forcing doctors to euthanase or doctors being concerned about being involved in this process. There is a minister of the Crown in the other place who does not seem to be concerned about the process, because he carried it out.

Several members interjected.

Hon ROBIN CHAPPLE: I have his remarks and I will read them out in a minute. Doctors make this sort of decision all the time—the dose of double effect. Some doctors do it at a level at which it may or may not incur an outcome of death. I support what the honourable member in the other place did. He administered a dose of double effect that he acknowledges he advised the patient and the relatives would most probably cause death, and asked if they were okay with that and they said yes. That is a tremendous outcome.

Hon Helen Morton: What did he do it for?

Hon ROBIN CHAPPLE: It was a pain killer, a known respiratory suppressant.

Hon Helen Morton: Why did he need to give that level of help?

Hon ROBIN CHAPPLE: The patient was in pain.

Hon Helen Morton: So it was to relieve the pain?

Hon ROBIN CHAPPLE: Yes. I will read out Dr Kim Hames' words —

I warned the family that the dose of painkiller that I was about to administer was a respiratory suppressant, can stop that patient breathing.

Did they want me to do that? Did the patient want me to do that?

The patient and the family said yes, so I administered that dose of painkiller.

What I did was give pain relief, and the side effect of that pain relief resulted in that patient dying then rather than in half an hour's time.

I support what he did; he was compassionate. He did what a doctor should be doing.

Hon Helen Morton: It is legally possible under existing legislation.

Hon ROBIN CHAPPLE: That is debatable.

Hon Helen Morton: It is not debatable.

Hon ROBIN CHAPPLE: Of course it is.

The PRESIDENT: Order! Let Hon Robin Chapple make his final comments through the Chair.

Hon ROBIN CHAPPLE: Thank you, Mr President.

I would like to thank Hon Lynn MacLaren for her comments. The reflections on her Christian background are new to me. Well done. She referred again to the evidence in Oregon where there is no slippery slope and I thank her for her passionate support.

I thank Hon Ken Baston for acknowledging there are lots of safeguards in the bill and that there is a cooling-off period and for noting that nothing can deal fully with the prospect of getting financial advantage. I respectfully indicate to the honourable member that the bill deals with this matter in a particular number of ways in clauses 9(3)(c), 11(1)(c) and in particular 16, which make the financial issues very clear.

One of the points Hon Ken Baston mentioned was the difficulty getting doctors and, indeed, palliative care into regional areas. This is my regional area also. In the Pilbara we have one palliative care officer, who does most of her palliative care via the phone. That is good palliative care? We are in furious agreement that we need better palliative care.

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I thank Hon Ed Dermer, MLC. We have had long and fruitful debates in the corridor. Essentially, we agree on all aspects of health care, especially the funding of palliative care. He quoted a paper from the House of Lords, but, interestingly, he did not read the latest paper I referred to earlier, did he?

Hon Ed Dermer: I did; I read both.

Hon ROBIN CHAPPLE: The 2007 paper?

Hon Ed Dermer interjected.

Hon ROBIN CHAPPLE: But it does not even speculate on the slippery slope; it says there is not one.

Hon Ed Dermer: I was quoting the one I was quoting, Hon Robin Chapple; I thought it was a very good one!

Hon ROBIN CHAPPLE: I thank Ed Dermer for his quote on the study in Holland. It sounds as though the papers were similar to the 2007 paper I just tabled. There were conclusions to support my argument in that same paper, so again, I thank him for that. The honourable member also quoted some opposition to my bill. I know Ed's view on this —

Hon Donna Faragher: Hon Ed Dermer.

Hon ROBIN CHAPPLE: Sorry; Hon Ed Dermer. I do apologise. Ed was calling me Robin, the minister may remember, so I am just returning the favour.

In relation to that, quite clearly we have had a good debate on this over a long period of time, and I actually do understand where Ed is coming from. It is a pity he just cannot be a bit more up-front about it, but well done.

Hon Ed Dermer: Just how up-front do you want me to be, Robin?

The PRESIDENT: Order, members! Let Hon Robin Chapple sum up.

Hon ROBIN CHAPPLE: Hon Ken Travers said that we could spend considerable sums of money and bring down the road toll, but governments of different stripes over time have not done that. That is an excellent observation. Hon Jon Ford made a similar observation in relation to the funding of medicines. Hon Ken Travers went on to make a range of points, all of which I agree with. I thank the member for his support for the second reading, although I understand the member may not necessarily be supporting the bill at the third reading stage. Again, I hope that we will get to the committee stage and I will have the opportunity to address some of the member's concerns in more detail.

I turn now to Hon Helen Morton, MLC. It was very good to hear that she has had meetings in her office with groups who are for and against the bill. I thank the member for engaging in that way. I am fully aware of the range of palliative care options and palliative care specialists. My dialogue with palliative care groups and with the board of Palliative Care WA indicates that, in certain cases, they cannot manage pain. So I think we need to be very clear that although palliative care strives to do its very, very best to manage serious pain, there are cases in which it cannot do that.

I turn now to "natural safeguards". What natural safeguards were there when Hon Kim Hames acquiesced to the wishes of his patient and his patient's family? Was he protected under law? Was the patient protected under law? Was the family protected under law? My advice is that maybe they were not.

Even though they receive the best palliative care available anywhere in the world, 25 per cent of late-stage cancer patients experience moderate to severe suffering. That comes from Wilson K.G. et al in a paper in the *Journal of Clinical Oncology*, 2007. There are more papers to support that, from the Palliative Care Australia website in 2006; from Dr Odette Spruyt, society president, and her view that, "It is simplistic to argue that palliative care can remove all suffering at the end of life", from the article in *The Age* that I have referred to; and from an AMA position statement on the role of medical practitioners in end-of-life-care in 2007. These papers all attest to the fact that palliative care cannot deal with 25 per cent of late-stage cancer patients and prevent them from experiencing severe suffering. There are many other papers on this issue. I will not take up too much of members' time on this.

Hon Liz Behjat: And a lot of advances have been made in the past four years.

Hon ROBIN CHAPPLE: Absolutely. I have been discussing these issues with palliative care, but they were still telling me as recently as one month ago that they cannot control end-of-life pain.

Hon Max Trenorden said that he had received 33 emails opposed to voluntary euthanasia and two in support—how many letters?

Hon Max Trenorden: That was the lot, but I said that they were only from my electorate.

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Hon ROBIN CHAPPLE: No problem. It is interesting that when we look at that Newspill, it shows that Hon Max Trenorden's electorate has the highest support for voluntary euthanasia anywhere in Australia. As the member knows, people with passion send emails and letters.

Hon Matt Benson-Lidholm asked what qualifications doctors will have to have to be involved in this. I suppose the key issue is that doctors have the qualifications that they gain through their academic process. The Voluntary Euthanasia Bill 2010 will ensure that the doctors who operate in this area have been operating as a fully qualified doctor for at least five years. Hon Matt Benson-Lidholm quoted Dr Watson, who was at a Notre Dame University conference, but one must remember that that conference was a conference about opposing voluntary euthanasia, so it could not be seen to be a broad-ranging conference; in fact, people were brought from all over the place to go to that conference.

Hon Kate Doust stated that doctors do not appear to have been consulted about the bill, which I think was addressed by Hon Giz Watson to some extent. To make it very clear—as I did in the answer I gave to Hon Michael Mischin the other night when he asked me a question—I have, indeed, consulted doctors widely. I named a couple who were prepared to be named, but many, because they have been involved in the “dose of double effect”, do not wish to be named. Hon Kate Doust also stated that it is only on very rare occasions that pain relief cannot be provided, but Hon Kate Doust agreed that those occasions do arise.

Hon Kate Doust also talked about people with terminal illness. Of course they are going to be depressed, and that matter is addressed in the bill. She went on to talk about being very concerned about Holland, Belgium and Oregon, and I have dealt with that. Quite clearly, the evidence is that it is a functioning process that is under review, and it is a process that is now working in tandem with palliative care.

On the subject of recognised drugs, we are not people who have any experience in the administration of any type of drugs. That is not our job; we are lawmakers. It will be left up to the medical professionals to determine the right drugs or the quantity of drugs to be used at the time, and that will be by regulation.

I was also asked who had overall oversight of the bill; it is the State Coroner and the Parliament, as stated in clause 14(3), 14(5) and 14(6). I was also asked how people could prove they are residents. Regulations can be made about that aspect. Residency is a relevant concept for lots of things such as taxation, and it is another regulatory process.

A question was asked about the time period of two years when, quite often, a terminal illness is short and sharp. Certainly, two years is the extension, but the ability to deal with matters in a short and sharp framework is there; and it will be dealt with in exactly the same manner as something that might occur in two years' time.

I was asked about the witnesses and applicants being 18 years old versus 21 years old. That is to avoid concerns about death tourism, so people must have been an adult in WA for three years to apply. That encompasses that whole three years of residency and reaching the age of 21 years. There is no need for the witnesses to have been an adult in Western Australia for three years, so they are just normal adults. As for staying with the patient until death ensues, I just reiterate that I used the word “instantaneous”. It is not necessarily instantaneous; in fact, the process might take a matter of minutes, but it is in essence very quick.

Hon Liz Behjat: How can you say that when you do not know what drugs they are going to use?

Hon ROBIN CHAPPLE: I say that because in other nations the types of drugs that will most probably be used are being used and eventuate in that outcome. As drugs develop and new drugs come on board, different applications and different drugs will be used.

Hon Simon O'Brien said that we need to defend the right to life, but as Dr Rodney Syme said, as I quoted him in my second reading speech: the right to live does not include an obligation to do so in every circumstance. Dr Erik Leipoldt has said that we need a caring society. Dr Leipoldt has a very considered view on this, and I have been in regular, respectful contact with him. It is interesting to compare his view with some disability advocates globally who feel that seriously physically disabled people are effectively discriminated against if they are unable to commit suicide as an able-bodied person might. There is therefore a diversity of views among people with disabilities, just as there is in society generally. I took a lot of the views of Erik Leipoldt into consideration in the crafting of the bill to ensure that I dealt with his concerns that disabled people were not going to be covered by this legislation, because he is a shining example of somebody who was seriously injured, went through a serious depression and then came out of the other side. As I said, he gave me the view that the bill should be very narrow and very prescriptive.

Hon Adele Farina said that it seems that community support is stronger for this issue, and I agree. She expressed concern about lack of access to doctors in the regions. I have addressed this earlier, but would attest to her

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concerns that it is a problem in my electorate. On the question of how an executor might determine the proposed section 16 forfeiture of financial benefit, the government may make regulations on such issues if they are needed to flesh out such detail should the bill become law. Legal advice will no doubt be sought on key provisions. Practice will build up and such minor legalities will be ironed out. They are not central to the bill. What is central to the bill is ascertaining whether the applicant comes to expressing this preference by reference to all of the criteria in the bill.

There was an interesting point, which again could be fleshed out during the committee stage, and that was the payment of witnesses. It was said that we may end up having professional witnesses. It is not something that I had considered and not something I feel strongly about, so I am prepared to consider an amendment if the bill gets to the committee stage. On the question of excluding family and friends from being witnesses, we will most probably need to deal with this in more detail during the committee stage. We are being ultra-safe in trying to distance from the process anyone who might be considered to be possibly exerting an inappropriate influence on an applicant. On the question of the double effect, Hon Adele Farina commented that I struggled with the distinction of the double effect in response to Archbishop Hickey on this.

Again, I would like to thank members for their contribution. I think it has been a serious, well-meaning debate in which people have all said what they firmly believe, and that is the way good debates should be.

I do not know whether I will be in this chamber during the next term of Parliament, or maybe in another chamber; or in another world, even. However, if I am here, I will reintroduce voluntary euthanasia legislation. If I am not here, I hope that one of my colleagues who might be here will continue my charge. I thank members.

Question put and a division taken with the following result —

Ayes (11)

Hon Robin Chapple
Hon Sue Ellery
Hon Adele Farina

Hon Jon Ford
Hon Philip Gardiner
Hon Lynn MacLaren

Hon Linda Savage
Hon Sally Talbot
Hon Ken Travers

Hon Alison Xamon
Hon Giz Watson (*Teller*)

Noes (24)

Hon Liz Behjat
Hon Matt Benson-Lidholm
Hon Helen Bullock
Hon Jim Chown
Hon Peter Collier
Hon Mia Davies

Hon Ed Dermer
Hon Kate Doust
Hon Wendy Duncan
Hon Phil Edman
Hon Brian Ellis
Hon Donna Faragher

Hon Nick Goiran
Hon Nigel Hallett
Hon Alyssa Hayden
Hon Col Holt
Hon Robyn McSweeney
Hon Michael Mischin

Hon Norman Moore
Hon Helen Morton
Hon Simon O'Brien
Hon Ljiljana Ravlich
Hon Max Trenorden
Hon Ken Baston (*Teller*)

Question thus negatived.

Bill defeated.