

Voluntary Assisted Dying Bill 2016

Parliament of Tasmania

House of Assembly

November 2016 – May 2017

Hansard

(uncorrected)

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1. House of Assembly – Thursday, 17th November 2016

LEAVE TO SUSPEND STANDING ORDERS

Voluntary Assisted Dying Bill 2016

[11.21 a.m.]

Ms GIDDINGS (Franklin - Motion) - Madam Speaker, I seek leave of the House to move that so much of Standing Orders be suspended as would prevent this matter from being debated forthwith.

This is a matter I raised this morning with the Leader of Government Business. It is not a motion I understood I had to move because of precedence in this Parliament in regard to bills being presented under two names, but the Clerk has informed me this morning that the current Standing Orders do not allow for a bill to have two names. Therefore in order for the bill to be tabled today I am now seeking to suspend Standing Orders for that purpose.

[11.22 a.m.]

Ms O'CONNOR (Denison - Leader of the Greens) - Madam Speaker, I support seeking of leave to suspend Standing Orders so Ms Giddings and I can table together the Voluntary Assisted Dying Bill 2016. In my experience in this place there is plenty of precedent for the co-sponsoring of legislation. In relation to this legislation, members are aware that this issue is one of significant public interest. There is enormous public support for this legislative reform and we encourage the House to support us in tabling this bill together as co-sponsors.

[11.23 a.m.]

Mr FERGUSON (Bass - Leader of Government Business) - Madam Speaker, this is highly irregular. It has only ever happened once before in the history of this House. As Ms Giddings has shown by her comments, there has been a sense of amnesia by members opposite who not long ago were members of this House in government together. They seem to have forgotten the Standing Orders have not, do not and have never sustained more than one member's name being on a bill. The sessional orders passed by the previous Labor-Greens government allowed only for the period of that parliament for a bill to be co-sponsored by more than one member. It was a fiddle then and it is a fiddle now. It is Labor and the Greens again joined at the hip.

The Government was astonished to hear it was left until today for the Labor Party and the Greens to realise they had made a fundamental error in thinking they could bring a bill to the Parliament with more than one member's name on it, which is almost without precedent. It was only allowed when the Labor-Greens government combined to allow Ms Giddings and the Leader of the Greens, Mr McKim, to co-sponsor a bill and manipulate the sessional orders to allow for that to happen. It is poor that Labor has forgotten that is what they did. No reference has been made in relation to this matter to the Standing Orders Committee for any consideration of whether this is proper and good practice. There was no use yesterday of Labor's or Greens' private members' time where they could have visited this matter, but they were not organised. They have failed to be prepared and have obviously had poor advice.

Having said that, the Government would not be supporting any move to change the Standing Orders in relation to this matter but if Labor and the Greens again want to present a co-sponsored bill to show they are still joined at the hip, the Government will not stand in their way.

Leave granted.

SUSPENSION OF STANDING ORDERS

[11.26 a.m.]

Ms GIDDINGS (Franklin - Motion) - Madam Speaker, I move -

That so much of Standing Orders be suspended as would prevent the Voluntary Assisted Dying Bill 2016 from being introduced by more than one member forthwith.

While some of those comments from the Leader of Government Business shows he was a little reluctant to support the position today, I note that he and the Government have agreed to suspend Standing Orders. For that I thank him and members of this Parliament.

This bill is a conscience bill. It is a private members' bill, not a party bill. It is a bill that is largely based on a bill that came to this Parliament in 2013. It is a bill that has been improved following work in Victoria with a very thorough parliamentary inquiry that came out in favour of voluntary assisted dying legislation being introduced in that state. It also follows a Supreme Court decision in Canada, which made a stronger case for voluntary assisted dying than the legislation that has subsequently been adopted by the Canadian parliament. Nevertheless the Canadian parliament has brought in substantial laws that enable Canadians who are suffering intolerable pain the right to choose the timing of their own death to end their suffering.

This is a very important bill that this Parliament needs to debate again. It is an issue that will not go away while there are Tasmanians who continue, and will continue, unfortunately, to suffer intolerable pain due to their medical condition.

We know that palliation helps most people and we strongly support palliation. We also know that there is a very small percentage of patients who will never end their suffering and their pain through palliation. There is strong evidence from the palliative care sector showing that not every patient they treat has their pain and suffering ended through palliative care and treatment.

It is that very small percentage of people who we aim to assist. People who have no alternative, people who under this bill must pass a very high test to be permitted to enact the powers that we would hope this Parliament would support. You must have a medical condition that is in its advance stages, which is incurable and irreversible. You must be experiencing persistent suffering that is intolerable. There must be no other treatment or palliative care option that could relieve that person's suffering that is acceptable to the person and there is no reasonable prospect of a permanent improvement in their condition. They must be competent and understand their condition.

These are all critical to ensure that we are not talking about providing open slather for people, but we are talking about helping people who are suffering intolerable pain to have a choice about the timing of their own death. You only have to look at the work of Andrew Denton, the Go Gentle Australia

group and the publication they have released. Read the stories of family members who have watched loved ones die a painful and terrible death, or read the stories of those who are living with that awful pain and want but cannot get relief through modern medicine, cannot get relief through palliative care, and you understand how they desperately want to have that choice.

Around the world where people do have a choice only a very small percentage ever take up that option. Most of us want to live every minute that we possibly can. We do not want to leave our loved ones. We want to be with them. For some people they are putting their own loved ones at risk. They are committing suicide if they do not have any other option. We only have to read the coroners' reports from Victoria to see that that is exactly what is happening. So why should we be leaving Tasmanians in a position where they choose suicide in circumstances that are horrible, without loving care and attention, without medical supervision, without family around them in a supportive environment so that they can end awful pain and suffering?

We have deliberately tabled the bill today to allow members to look at it carefully and to consult with people in their electorate over the parliamentary break. We are open, Ms O'Connor and I, to talk with members about the bill and any issue or concerns they may have.

We do not see this as opening up a debate about whether you have a voluntary assisted dying process or not, but here is a legal framework. We want to work with all members of parliament to ensure that should this become a historic moment in this state, we provide the most robust legal framework we can to enable people to end their intolerable suffering and see them have a peaceful death in an otherwise very difficult circumstance.

I welcome the role Ms O'Connor has played in helping to work through this bill. I also note the presence of Margaret Sing and members of the Dying with Dignity group. Margaret has been a gem during work on this legislation. We have been able to bring improvements to the bill that was presented back in 2013 based on further research and further knowledge gained from other jurisdictions, particularly the historic work of the Canadian government and the Canadian Supreme Court. It is time politicians, governments, and people had a proper legal framework to enable decisions to be appropriately made, appropriately supported and within a legal framework.

I appreciate that the Government has supported the tabling of this bill to this point and we look forward to debating the bill in 2017. I hope all members will be offered a conscience vote in this House on the bill. We will see, as we have seen in the past, some of the strongest and most memorable debates in this House when we confront such a significant issue as this one.

Time expired.

[11.33 a.m.]

Ms O'CONNOR (Denison) - Madam Speaker, I thank my colleague Ms Giddings, shadow attorney-general, for the enormous amount of work she has put into developing and reworking the original legislation from 2012. It has been a relatively long process but we are here today with legislation which we believe is a safe and strong framework for allowing people who are experiencing intolerable and unrelievable suffering to make their own choices about their lives.

Ultimately, this is a fundamental human rights issue. It is about individual autonomy; our right to make choices and to decide about our lives. If we are in a situation where we have been diagnosed with a condition that is going to cause irredeemable, unrelievable suffering then individuals should be able to make a choice, because ultimately who is the state or any person to tell a person who is in agony and suffering that they cannot make the choice about how their lives will end. I thank Ms Giddings for her advocacy on this issue going back a number of years now.

I also thank the wonderful Margaret Sing from Dying with Dignity Tasmania who has been a champion. I remember the joint standing committee in 2008-09 where both Houses examined dying with dignity legislation brought forward initially by the then leader of the Greens, Nick McKim. Margaret's work and tireless advocacy for this important reform is much appreciated by us, and for everyone in Tasmania who recognises this is a reform for which the time must come.

Time after time, in public polling, you see the level of support for the right to choose, should you be diagnosed with an illness that causes irredeemable, unrelievable suffering, is very high. It generally sits at around 80 per cent of public support. This is an issue that goes to people's sense of autonomy and their right to make decisions about their own lives. In South Australia, at about 3.30 a.m. this morning, their assisted dying legislation was voted down by a single vote, when the Speaker cast a deciding vote.

That is one setback. Our advocates for reform, who recognise this is a matter of human dignity and compassion, are well accustomed to the steps this reform takes. Sometimes you feel as if you are going backwards. This change will come. There are now 13 jurisdictions where voluntary assisted dying is legal. Two more have voted to implement voluntary assisted dying in the United States - Oregon, Washington, Montana, Vermont and California - with Colorado and Washington DC soon.

Momentous changes took place in Canada. One of the most critical elements of successful introduction of a dying with dignity framework in Canada was the willing participation of the Canadian medical fraternity in developing a structure, working with government and the Parliament, which respected the Supreme Court's decision and had significant safeguards.

We would love to have a member of the Liberal Party with us on this legislation. We believe this legislation should not be made political. The Leader of Government Business in the House is wrong to say this is Labor and the Greens. It is not. This is a corresponsive private member's bill. Ms Giddings and I decided to work together on this issue because we recognise this is reform people want. It is a private member's bill. Every member in this House, when we bring the debate on, will have an opportunity to contribute.

As Ms Giddings said, when we have conscience debates this place is at its best. The invitation is open to any member of the Liberal Party room to join us in this legislation so that there is a tripartisan approach to this. People in the community would warmly receive that. We respect people have strong views on this issue, in this place and out in the community. This is about making sure the law in Tasmania protects people in agony, who are suffering, and for whom palliation does not provide relief. We know those people are out there.

During the 2009 debate a magnificent human being, Robert Cordova, was in here. Robert Cordova was suffering from motor neurone disease. He was desperate for this legislation to pass. Ultimately, in order to save his family from the risks associated with assisting him, Robert Cordova took his own life. This is happening every single day and week in Tasmania and around the country. People who are not protected by the law, as it is, are forced to make the most horrible choices, sometimes on their own, without a doctor present. Every single day, in this country, doctors are making decisions about people's lives. Involuntary euthanasia is being practised in this country for the best of reasons; through compassion.

Thank you to the Government for agreeing to the suspension of Standing Orders in order to allow this co-sponsored bill to go forward. We encourage everyone to treat this matter seriously, and represent their constituents.

Time expired.

[11.40 a.m.]

Mr FERGUSON (Bass - Leader of Government Business) - Madam Speaker, in addressing the motion, and I do this on behalf of the Government, I note the motion before you as Chair is to suspend the Standing Orders purely in relation to Standing Orders that require a single member's name be placed on a bill. We are currently resolving this. I have indicated the Government will not stand in the way of that occurring. I stand by everything I said previously.

I rise to speak on this matter on behalf of the Government. In doing so, I recognise there may potentially be a range of views in an environment of a free vote. For that reason, I will not attempt in any way to represent those views. This is a motion about the suspension of Standing Orders to allow joint sponsorship of the bill. Comments have been offered in this current debate, which I note Madam Speaker has been comfortable with members making.

Madam SPEAKER - Given the nature of it. If it is being questioned I can explain to the House that it is important to allow members the opportunity on a matter of conscience.

Mr FERGUSON - I am not questioning that. I will wish to do the same. This question before us today will be one that is not specifically about palliative care, euthanasia, mercy killing, or assisted suicide, but the suspension of Standing Orders. The Community Development Committee, at the instruction of this House, currently has an inquiry under way, and has a reference to examine end-of-life care. It includes a number of references, which go to matters relevant here. That was at the instigation of the member for Denison, Ms Ogilvie.

The Government takes all matters around end of life care and end of life legal rights seriously. That includes me as Minister for Health, and the Attorney-General, in relation to members of the community's rights to have their wishes understood by family members, for example, in the area of advanced care directives. We take that very seriously. We were supportive of those areas of law being given fresh eyes by the Community Development Committee. The Community Development Committee, which is chaired by Mrs Rylah, has not yet reported. I do not know when it will report. It does not have a reporting date, but we anticipate the report of the committee being presented back to members of this House. When it does, it will inform a considered debate that inevitably can and should occur.

Although we have not seen the bill yet, but if the bill is anything like the previous bill presented in the previous parliament, there may be issues to be considered. It was not long ago this bill was voted on by this House. I think it was three years ago and also note openly that this is a new Parliament and there are new members of this House who have not had their position on this matter tested or considered.

We respectfully anticipate future debate on this. The Government free vote or conscience vote is not relevant. The Government will look at the bill as a matter of prudence and good public policy. The Liberal Party affords a free vote to members of its Party in relation to life and death decisions. This case will be no different, if and when the bill is brought on for debate.

[11.44 a.m.]

Mr LLEWELLYN (Lyons) - Madam Speaker, on the issue of suspension of Standing Orders, the Leader of Government Business made note of the fact that Standing Orders do not contain a provision, and that the previous government introduced sessional orders that provided this. This needs to be referred to the Standing Orders Committee because there may be issues of this nature in the future. There should be a provision that allows co-sponsored submissions to be introduced into

this Chamber. There are a number of other issues in the Standing Orders that also need to be addressed. I urge the Government to consider this matter in the Standing Orders Committee in future.

Standing Orders suspended.

VOLUNTARY ASSISTED DYING BILL 2016 (No. 73)

First Reading

Bill presented by Ms Giddings and Ms O'Connor and read the first time.

2. House of Assembly – Tuesday, 23rd May 2017

SITTING TIMES

Mr FERGUSON (Bass - Leader of Government Business - Motion) - Madam Speaker, I move - That the House not stand adjourned at 6 o'clock but continue to sit past 6 o'clock on Wednesday 24 May, and that for that day so much of the Standing Orders be suspended as would prevent –

- (1) The order of the day for the second reading of the Voluntary Assisted Dying Bill (No. 73) 2016 from immediately being called on at the conclusion of the debate on the matter of public importance.
- (2) In respect of such proceedings on the bill –
 - (a) On the main question that the bill be now read a second time; the member for Franklin, Ms Giddings, the member for Denison, Ms O'Connor, member for Bass, Mr Ferguson, may speak for 30 minutes and other members may speak for 20 minutes;
 - (b) no reply pursuant to Standing Order 162 shall be allowed to either the member for Franklin, Ms Giddings, or the member for Denison, Ms O'Connor;
 - (c) the debate on the second reading stage of the bill, including any subsidiary motions, shall conclude at 10.05 p.m. on Wednesday 24 May and for the purposes of bringing to a conclusion such proceedings on the expiration of the time allotted, the Speaker shall forthwith put any question already proposed from the Chair and following which shall, as the case may be, put the main question or the main question as amended; and
 - (d) following the vote on such question further proceedings of the bill, if any, shall be made an order of the day for tomorrow; and
 - (e) the House shall immediately adjourn without debate.

Madam Speaker, this is the product of much discussion between members of this House, noting that the bill itself has been declared by at least the Leader of the Government as a free vote for members, and no doubt the same for others. This is the Government seeking to work in the Chamber to facilitate a thorough discussion of the bill and also to ensure certainty of a conclusion within the agreed time frames. I commend the motion the members of this House.

[11.21 a.m.]

Ms O'CONNOR (Denison - Leader of the Greens) - Madam Speaker, I make a brief contribution in response. I thank the Leader of Government Business in the House for being quite helpful in preparing us for the debate tomorrow. I understand all of us have strong feelings about this issue and this legislation we will be debating tomorrow, and I recognise that Mr Ferguson is among those who has very strong feelings. I place on the record my personal thanks for the assistance - even though it has not been perfect - he and his office have given in preparing the House for the debate tomorrow.

There are many people who will be watching the debate tomorrow. There will be a rally on the lawns of Parliament at 1 p.m. for people who support this important reform. As everyone in this House

knows, conscience debates are the most meaningful and profound debates we have in this House. I hope that every member takes the opportunity to speak from their heart on this legislation because it is really important that we have a proper debate on this reform, which has overwhelming public support.

[11.23 a.m.]

Mr LLEWELLYN (Lyons) - Madam Speaker, I indicate my appreciation for the discussion that occurred with respect to coming to an agreement with regard to this issue. The Labor Party supports the motion.

Motion agreed to.

3. House of Assembly – Wednesday, 24th May 2017

VOLUNTARY ASSISTED DYING BILL 2016 (No. 73)

Second Reading

[11.56 a.m.]

Ms GIDDINGS (Franklin - 2R) - Madam Speaker, I move -

That the bill be now read the second time.

Here we are debating voluntary assisted dying legislation again. Why are we doing so? People are given no option other than to live with pain and suffering every day of their lives, or to take their own lives in often horrible and tragic circumstances. This issue will not go away. Jurisdictions across the world are responding to similar demands. There are now eight countries and six states in America, as well as Washington DC, where you can die with assistance.

The Northern Territory remains the only Australian jurisdiction to have passed euthanasia laws, only to have had them overturned by the Australian Government. However, there is a people's movement building for reform in Australia. Rather than continuing to wait patiently for we politicians to support voluntary assisted dying legislation, these people are demanding that we show courage, compassion and leadership on this sensitive issue.

The question is, will we do so today? We have read and listened to the tragic stories given voice through the advocacy of Andrew Denton and Go Gentle Australia. We have shared the pain of Nikki Gemmell writing of her mother who was driven to a lonely and desperate suicide, not able to live anymore with her unbearable pain. We have shed tears watching stories on our televisions of people like Rose who took her own life as she was losing her ability to speak, to walk, to eat and to live without pain.

Poll after poll continue to show around 80 per cent of people support voluntary assisted dying laws in this country. People want a choice to be helped to die. Through this bill, we have an opportunity to provide them with that choice.

Since we last debated this issue in 2013 there have been Supreme Court decisions, inquiries, legislation debated both won and lost across the world. Perhaps some of the most powerful and disturbing information that has come to the fore is the evidence given by the Coroner's Office in Victoria as part of their parliamentary inquiry. That evidence showed starkly how people are making their own choices right now by way of unregulated, unsupported, and lonely suicide. Just as Nikki Gemmell's mother did, they are on their own without family or medical support, too frightened to tell their loved ones in case of implicating them in a crime.

The Coroner's Prevention Unit in Victoria studied suicides where the deceased took his or her life after experiencing an irreversible deterioration in physical health due to disease or injury. They found 240 people out of 2879 suicide deaths between 2009 and 2013 met that criteria, accounting for around 8 per cent of suicides investigated at that time. Most overdosed. Some used firearms; 13.3 per cent of deaths. Imagine coming home to find your loved one dead through the use of a firearm. Others hanged themselves. Within my wider family, we have experience of exactly that, coming home to find a relative hanging.

We cannot continue to ignore the realities of what is happening and why people are being driven to suicide. For them, they have no other option. They are in pain. They are suffering, and where is our compassion for these people? By continuing to ignore this issue we leave people and their families vulnerable.

The bill we are debating today includes changes made to the 2013 bill to take into account the issues raised by the Tasmanian Law Society at the time of the last bill. Key sections have been strengthened and clarified, including what it is to have an eligible medical condition, the need for specialist diagnosis right at the beginning, the definition of 'primary' and 'medical' practitioners and the independence of the two doctors. We have also considered approaches raised through various inquiries and legislation developed in other jurisdictions since then. However, the crux of the model remains the same. It is person-centred, respects the role of doctors, and contains multiple proven safeguards.

Whilst some members may be considering sending this bill to a parliamentary committee for further inquiry, I do not believe that is necessary. To send this bill off to a committee would be just another delaying mechanism, playing into the hands of those who will fight this reform tooth and nail no matter what model is put forward. We are elected to make decisions on the Floor of this parliament and it is time we made them on this issue.

The 2013 bill was thoroughly consulted. I can show members evidence of hundreds of submissions we received. Through that process we used the skills and expertise of experts in law and palliative care and beyond. We were able to use the skills of the Office of Parliamentary Counsel to assist in the drafting, which is rare for a private member's bill in this Chamber. The bill was supported by Professor Margaret Otłowski, a highly respected legal scholar in the area of voluntary assisted dying and it drew on the expertise of Professor Michael Ashby, clinical director of palliative care, Ms Lisa Warner, the then Public Guardian, and so many others.

The 2016 bill was tabled in November of last year and the consultation process has ensued with key stakeholders, including the AMA and the Law Society, neither of whom chose to comment this time around, other than I understand that representatives of the national AMA flew in yesterday with the same arguments they have used against every bill around this country. I will come back to doctors later in my speech.

I should say that both Cassy and I have addressed a number of community groups during this time, including groups such as Rotary, and the experience there was overwhelming support for this legislation.

Let me be clear: this is not a debate about palliative care. Any argument that says all we need to do is fund palliative care better is a cop-out and deliberately fails to recognise the limitations of our palliative care system that go beyond funding or a person's access to palliative care or ability to make an advance directive.

Do not get me wrong - our palliative care system is run by people who are compassionate and they help the vast majority of Tasmanians to experience a comfortable death. In fact, our bill requires everyone to consider all palliative care options, knowing that for most it will be sufficient to give them a comfortable death, a good death, but palliative care does not take away the pain and suffering for everyone. Listen to the story of nurse Anne Maxwell on the Go Gentle website. A small number of people will continue to suffer no matter what pain relief is given. These are the people who are depending on us to provide them as a last resort with a right to end their life at their own choosing. That is exactly what this bill does.

Palliative Care Australia recognises there is a cohort of terminal patients, around 5 per cent, for which palliative care is unable to provide satisfactory relief. The National Report on Patient Outcomes in March 2016 confirmed that not all patients can have their pain relieved. Do we really think it is right for them to have to suffer a horrific death, or as the Canadian Supreme Court said, be offered a cruel choice between that and desperate suicide? These patients are suffering intolerable pain that cannot be relieved and their families are being left with the stressful memories of their loved one's dying experience. The law, as it is, gives them no choice to end their suffering and pain.

Many of us in this Chamber know Andrew Denman and he is here today. We know him for his passion for our specialist timber industry. What you may not know is he is also passionate about seeing voluntary assisted dying laws implemented in this state, having watched his mother, Carol Dawson, die a long, protracted, terrifying and painful death. An advance directive to cease food and water to allow her to die was enforced; however it was also part of the horrific death she experienced. Carol starved herself to death because she had no other option and she suffered - and I quote - 'strong pain, so much so she has bitten her lip so hard it is bleeding and her whole face is scrunched up in pain'. This is what Andrew wrote in his email to me of her death. He went on:

Another injection - more pain. More suppositories - more indignity. It is excruciating to watch knowing that I made a promise to her not to ever let things get to this stage and will be forever haunted by mum's pleading looks every time her eyes partially open asking me to end it all.

It was only after Andrew threatened to take his mother's life to end her pain that her doctor reluctantly increased the morphine doses knowing that would hasten her death. Andrew wrote on 3 February 2016:

Mum died this morning at 11 a.m. She died a so-called 'good death' imposed upon her by the government of Australia - a cruel, callous, heartless and gutless bunch of zealots. 13 days she lasted with no food or water. Death by dehydration until her internal organs fail one by one. I watched every unnecessary second of it. The gasps, the cries, the bleeding, the moans - state-sanctioned torture dressed up and sold as a 'good death'.

I have seen the photos of how Carol suffered and I know how much he and his sister continue to suffer in their grief, knowing they could do nothing more to help end their mother's pain and agony. Palliative care is not enough for some patients.

The Victorian inquiry also provided significant evidence that palliative care and medical treatment cannot relieve all suffering due to incurable and irreversible conditions. It is simply wrong to argue that it can. I believe it is cruel and inhumane to those who continue to suffer, regardless of the best palliative care they are receiving, to not recognise their suffering and help them to end it.

While I support advance directives and the work of my colleague, Ms Madeleine Ogilvie, and believe more needs to be done legislatively to give them legal force, an advance directive to stop treatment or feeding or to turn off the machine is not going to help these people to end their life peacefully and without pain.

We have heard from a family perspective, but what about that of a doctor? Doctors are at the front line and those such as Dr Heather Dunn have seen the intolerable suffering some patients are forced to endure in the palliative care system. She described some of the conditions she has encountered, and I quote:

There seems to be a simplistic misconception that TLC and an adequate dose of morphine is all that is needed for a 'good' death. But what about the patient with a bowel obstruction who needs to have continuous (& uncomfortable) naso-gastric suction to stop the faecal vomiting, or the people with end stage neuromuscular disorders who choke on their own saliva because they cannot swallow, or the person with abdominal cancer fungating through the abdominal wall and exuding an offensive discharge, or the person with liver cancer who is heavily jaundiced with incredible unremitting generalised itch as a result -

I could go on. These are not hypothetical cases designed to shock you. These are the stories of real people and their real situations with which I have been confronted in my palliative care experience. I might add that one discharged himself from hospital and put a bullet through his head in his back shed. Another was grabbed by a security officer as she attempted to jump off the Repatriation Hospital roof, and another starved herself to death. I implore you to see and get some understanding of the desperation some people experience in such situations, and this extends to family, friends and health workers. I am still haunted by the fact that I was put in the situation where the laws and my conscience were in conflict, and that I chose not to give these people the dignified death they craved because the law would not allow it.

People are listening more and more and there is a people's movement growing around the world and politicians are responding. In Canada it took a unanimous decision, 9-0, in the Supreme Court which ordered the government to take legislative action. In 2016, a law passed the Canadian Parliament to enable voluntary assisted dying, a law which interestingly - and I hope will give you some comfort - is closely aligned with that proposed in this bill. For instance, the law focuses on patients over the age of 18 who are suffering intolerably from a serious medical condition. Self-administration and doctor administration are provided for, as well as the necessity of having at least two doctors to assist each request. While the Canadian AMA, like the Australia AMA, originally opposed euthanasia laws, they got on board with the process and had their say. They developed guidelines and principles that helped frame the Canadian bill. If only our AMA would do the same.

In Victoria, Premier Daniel Andrews, who was opposed to euthanasia until he experienced his father's death from cancer, is facilitating a government process to consult on a voluntary assisted dying bill in line with the recommendations of the Victorian parliamentary inquiry. He is using the expertise of doctors, nurses, a palliative care specialist, an academic, a disability advocate and a lawyer to assist to develop that law. The inquiry recommended a model which would allow for competent adults suffering from serious and incurable conditions which are causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable to request assisted dying. Like our bill, three requests would be required - an oral, a written, and a subsequent oral request. Importantly, the inquiry found no evidence of any slippery slope, as often threatened by opponents of euthanasia legislation.

In South Australia, the Death with Dignity Bill 2016 was lost on a tied vote - 23-23 - in November last year on the third reading, after getting sufficient support on the second reading to go into the Committee stage to debate the elements of the system being proposed. Just recently a cross-party draft bill allowing for voluntary assisted dying has been released for comment in New South Wales. Not to be outdone, Western Australia is also looking at debating the issue, highlighted in that jurisdiction by the death of former executive director of the West Australian Cancer Council, Clive Deverall, who took his own life after suffering for two decades from a rare form of non-Hodgkin's lymphoma. People are already making these decisions and taking their own lives. Is it not time we provided a legal framework to make these decisions within?

I want to address those two issues raised by opponents. There is no evidence of any slippery slope occurring in any other jurisdiction. Neil Francis in his blog on the Dying For Choice website says:

Switzerland is perhaps the most 'inconvenient' case for slippery slope hypotheses, which might explain why assisted dying opponents usually avoid mentioning it. It has the world's oldest assisted suicide law, in effect since 1942. It is also the least prescriptive: the *only* specific statutory requirement is that any assistance rendered must *not* be for reasons of self-interest. That's it. Surely a law in effect for 73 years and devoid of *all* the complex requirements of others would be the foundation for an out-of-control assisted dying rate, much higher than the Netherlands at 3.7%? It isn't. In 2015, the rate for Swiss-resident assisted death was 1.4%. The rate including foreigners, or so-called suicide tourists, was 1.7%. That is evidence that there is no slippery slope.

The latest data from the Canadian Government interim update on assisted dying shows that in Canada for the first six months of their law, their rate of all deaths shows that 0.6 per cent have used assisted dying laws. Most of these people were people suffering due to cancer. In Oregon, the rate is 0.37 per cent. We are talking about very few people using the process available to them.

It is fair and reasonable to ensure that vulnerable people are protected under any voluntary assisted dying legislation. This bill does exactly that. It is not fair and reasonable to make others continue to suffer intolerable pain because there is a potential for vulnerable people to exist in our community. Elder abuse is an important issue and it is why protections need to be put in place and they have been. To do nothing is also elder abuse.

In a famous case here in Tasmania, that of Elizabeth Godfrey, and her son Bill Godfrey is here today, former Justice Underwood pointed out that it could be argued that as suicide is not illegal in Tasmania, by making it illegal to assist a suicide, was discriminating against those who by reason of their physical disability could not carry out their own suicide, a choice which is open to the rest of us. We have that choice, but those people do not.

I acknowledge many church leaders do not agree with euthanasia laws and I respect their right to their opinion, but I also believe other church leaders and members of their congregation who overwhelmingly support dying with dignity laws, deserve equal respect. A 2007 and 2012 Newpoll found 74 per cent, rising to 77 per cent, of Catholics and 82 per cent, rising to 88 per cent, of Anglican respondents surveyed thought doctors should be allowed to provide a lethal dose to a patient experiencing unrelievable suffering and with no hope of recovery.

A man of the cloth I greatly admire, Anglican Archbishop Emeritus Desmond Tutu recently said:

Dying people should have the right to choose how and when they leave Mother Earth. I believe that, alongside the wonderful palliative care that exists, their choices should include a dignified assisted death.

Likewise, retired Episcopalian Bishop, Reverend John Shelby Spong has written:

My deepest desire is to always choose death with dignity over a life that has either become hopelessly painful and dysfunctional or empty and devoid of all meaning. That is the only way I know that would allow me to honour the God in whose image I was created.

And former Archbishop of Canterbury, George Carey, changed his mind about the church's teaching on assisted dying, now saying that we should prevent 'needless suffering'.

A Minister at the Community of St Luke, Presbyterian Church in New Zealand, Glynn Cardy, said in his published sermon on Physician Assisted Dying:

... belief in the sanctity of life does not mean believing in the sanctity of suffering, or disregarding steps to avoid it.

In California, where physician assisted suicide is now legal, Governor Jerry Brown, a lifelong Catholic and former Jesuit seminarian, said:

I have carefully read the thoughtful opposition materials presented by a number of doctors, religious leaders and those who champion disability rights ... I have considered the theological and religious perspectives that any deliberate shortening of one's life is sinful ... In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.

Madam Speaker, the medical profession too is divided when it comes to assisted dying. However, like the broader community, there is growing support. You only have to look at the letter from Doctors for Assisted Dying Choice, signed by over 100 doctors - and Dr Scott Bell here today, I believe, is one of those - to see that more and more doctors are publicly willing to support such legislation.

While the AMA officially maintains a policy of opposing euthanasia, their recent survey, which they do not talk much about, showed only half of the doctors surveyed were against euthanasia. Importantly, more than half, 52 per cent, believe that euthanasia can form a legitimate part of medical care, and 45 per cent supported physician-assisted suicide. They know, and their policy recognises that there are instances 'where it is difficult to achieve satisfactory relief of suffering'. They have that in their policy. They know you cannot relieve the suffering of every single patient.

They also know that some of their patients are calling out for the choice to die. In an article published in the journal of the Royal College of Physicians in April 2016, Dr Linda Sheahan reported the results of a survey completed by 156 specialist palliative care physicians. Only 2.5 per cent said they had never had a request for assisted dying. An overwhelming 97.5 per cent said they had. Their patients had asked to be assisted to die. Dr Heather Dunn wrote back during the 2013 debate:

I am a strong supporter of Palliative Care and have had considerable experience in it. However, even the most vocal opponents of assisted dying will admit reluctantly, when pushed, that Palliative Care cannot, and does not, give adequate relief from intolerable suffering for some people.

Ultimately, this bill is about the patients. There are hundreds of stories of people taking their own life because they could not bear the pain and suffering any more, or who had suffered a terrible death. I had one of those stories again given to me yesterday where a gentleman who was suffering pain that could not be relieved drove himself into the River Derwent and drowned. That was his only option: to drive himself into the River Derwent and drown.

One other person was Robert Cordover - and Robert's wife, Nica and son, Gideon, are here today as well. Robert was a Tasmanian who suffered motor neurone disease, which was slowly paralysing him. It affected his swallowing and breathing, and he described the feeling as being like drowning. He compared his experience to waterboarding at Guantanamo Bay. His pain could not be controlled or managed. All he wanted was the right to die with his family around him. He took his

own life before he no longer had the ability to do so. Nica told me today he tried to have that conversation with his GP, with his specialist, and with the palliative care doctor, and none of them would talk to him about it. Too scared. None of them would talk to him about it. Go Gentle Australia has many more stories if you need any more convincing.

I will move quickly to the provisions of the bill. The first important point to understand is that no patient is compelled to go through a voluntary assisted dying process, nor any health service provider to assist a patient to die. Everything about this process is voluntary for all involved.

Second, this bill provides for a last resort option only. This is enshrined in clauses 11(b)(ii) and 22(2). You can only access this pathway when all other care and treatment options, including palliative care options, have been considered, discussed, understood, tried - all of those things with your doctor. It is limited to those who meet the eligibility criteria under clauses 9, 10 and 11, including that you must be over the age of 18 and you must be a Tasmanian resident.

Under clause 11, to have an eligible medical condition, you must have a serious, incurable and irreversible medical condition in its advanced stages with no reasonable prospect of a permanent improvement in that person's medical condition. The condition or the treatment must be causing persistent suffering that is intolerable for the person affected. There must be no reasonably available medical treatment or palliative care options that would relieve the person's suffering in a manner acceptable to that person.

There are umpteen safeguards which, if we get into the Committee stages, we can go into detail with you. They are around voluntariness, mental competence, informed decision, age of the person, formal request, consultation requirements, need for the secondary medical practitioner to agree, waiting periods, family notifications, and the list goes on.

Madam SPEAKER - The member's time has expired.

Ms O'CONNOR - Point of order, Madam Speaker, I move that the member's time be extended briefly.

Madam SPEAKER - I do not think you can. There is already a motion before the House that has been agreed by the House in relation to times. I cannot extend because we did suspend the usual Standing Orders to pass that motion. The member's time has expired.

Mr FERGUSON - Madam Speaker, with your indulgence, may I ask you a question on this? Would it be permissible if Ms Giddings has further contribution that it might be tabled and incorporated into *Hansard*?

Ms GIDDINGS - I am happy to table my speech; it is not a problem.

Madam SPEAKER - You will need to seek leave but it cannot be incorporated into *Hansard*. It will be tabled in the usual fashion with other documents.

Ms GIDDINGS - Madam Speaker, I seek leave to table my speech.

Leave granted.

[12.27 p.m.]

Ms O'CONNOR (Denison - Leader of the Greens) - Madam Speaker, I rise today with a strengthened resolve and a strange sense of *déjà vu* to speak to the Voluntary Assisted Dying Bill 2016. I am very proud to co-sponsor this bill with the member for Franklin, Ms Giddings, and to acknowledge her deep and dedicated commitment to this reform and outstanding contribution on the second reading speech.

I acknowledge the very many individuals and groups who have and will continue to advance the cause of reform, who will continue to push for this compassionate reform. It is underpinned by compassion and a respect for human dignity. This bill is designed to protect the vulnerable. It is designed to give medical professionals legal protection. The status quo of the law as it stands is completely unacceptable and it is also cruel.

Tasmanians, through this parliament, have been here before. The first time was in 2009, when then Greens leader, Nick McKim, brought on the state's first dying with dignity legislation. In 2013 the House again debated dying with dignity legislation, co-sponsored by Mr McKim and Ms Giddings. On both these occasions, regrettably, and although they were conscience debates, not one sitting Liberal MP voted in support of the bill, despite the fact it had been drafted by the Office of Parliamentary Counsel and extensively consulted over a long period.

On behalf of the vast majority of Tasmanians who support a safe, legal framework, on behalf of people whose suffering cannot be relieved by palliation, we are hoping this time it will be different. This is a reform that is long overdue in this country and in this state. It is a reform grounded in compassion and respect for human dignity, a reform that acknowledges right now, there are Tasmanians experiencing intolerable, unrelievable suffering due to an advanced, incurable and irreversible medical condition for which palliation does not provide relief. Right now there are Tasmanians contemplating taking their own lives because their pain, their loss of dignity are too great to bear.

We know from evidence put by the Coroner to the Victorian inquiry to end of life choices, the lack of a safe, legal, voluntary, assisted dying framework is driving people to suicide. We know it is happening and has happened here to desperately suffering people. These are the lonely and desperate suicides of people who palliative care cannot help. They are people like the late Matthew Kent-Goodman, a 55-year-old Tasmanian father and lawyer with an aggressive form of multiple sclerosis. Matthew made the decision to end his life three months ago. His father, Stan, told Anna Fromberg from ABC News in last night's story that if he could have had anything to say he would have been there in parliament banging on the door saying, 'Pass the legislation'. Mr Goodman said his son was very sad he could not have friends and family around him at the end. That is not a good death. That is a lonely and desperate death and we can do better. Stan said:

It just would have been a friendly environment to say goodbye. Instead he had to do it in a clandestine manner and that is not what I wanted for my son.

Madam Speaker, this cruelty has to stop. Under the law as it stands people who are suffering excruciating and incurable pain that palliative medicine cannot salve are vulnerable to prolonged agony and a terrible death. The question is what are we as lawmakers going to do about that? The recent Victorian inquiry into end-of-life care concluded:

The committee rejects maintaining the status quo as an inadequate head-in-the-sand approach to policy-making and the plight of Victorians discussed in this report.

The Victorian Government has been compelled by the evidence and has announced its intention to introduce a dying with dignity framework.

What about Tasmania? Are we going to deny that the lack of a safeguarded, legal, voluntary assisted framework is driving desperately ill and suffering people like Matthew Kent-Goodman to suicide? Are we going to protect patients and doctors under a strictly safeguarded framework, or are we going to continue to pretend that palliation has all the answers? Are we going to continue to ignore the suffering of that very small but significant percentage of Tasmanians to whom this legislation would offer a compassion of choice and all the protections of a rigorously safeguarded legal framework?

Right now decisions are being made by doctors out of compassion to end lives without patient consent. Involuntary euthanasia is happening every day in medical settings in this country. Sadly, there is a conspiracy of silence about the truth here. I will talk about some of the statistical evidence later in my contribution.

The Voluntary Assisted Dying Bill 2016 gives competent adult Tasmanian patients the choice in consultation with doctors. It offers strong protections to both patients and medical professionals and details the rights and responsibilities of every person involved in a decision at every step. Under our bill, no-one can be coerced or forced to participate. Most importantly, it gives patients the choice and control over their end-of-life decisions.

It is transparently clear that many of those who put fallacious 'slippery slope' arguments, those opposed, have not read the legislation. When I look at some of the emails that have been coming into our inbox in recent days, the flurry of anti emails, it is clear that most people who are opposed to this legislation have not read the bill. They have formed a series of assumptions based on the biases of some church leaders against this reform and on the basis of those assumptions they are writing to members of parliament in order to sway people and their correspondence contains deep misunderstandings about this legislation.

This bill was drafted by the Office of Parliamentary Counsel. It was extensively consulted over more than a year in the last term of government. It has been improved since the 2013 debate after consultations with stakeholders, including the Law Society. This bill contains strict safeguards, a fact acknowledged by Doctors for Assisted Dying Choice. I too acknowledge the presence in the Chamber today of Dr Scott Bell. I will read some of the correspondence from Doctors for Assisted Dying Choice. I hope members who received this letter have read it because it is a very important analysis of the provisions in this bill. For anyone who is concerned this bill is not robust enough, I urge them to read this letter. The letter says - and I am paraphrasing parts -

As such, it incorporates more clarity of intent, more safeguards and more compassionate understanding than all previous bills in Australia. It clearly indicates that there is no extension of the circumstances in which a person's life may be ended by a doctor or any other person except as permitted by the conditions of this act.

The letter then goes through the clauses to talk about the safeguards and says such things as:

Section 9 details the exact conditions that have to be satisfied before the person's primary medical practitioner can define the person as an eligible person and prevents slippery slope scenarios developing due to the specificity of the criteria to be an eligible person.

Section 10 further prevents any slippery slope by requiring the person's primary medical practitioner to determine that the person is competent and making the request voluntarily.

The letter concludes:

We have closely reviewed and analysed the Tasmanian Voluntary Assisted Dying Bill 2016. We believe it offers the Tasmanian community a further considered direction when planning end-of-life choices. As such, we see it as complementing the existing medical and palliative models. We urge you to enable a legislative pathway for this bill to be enacted.

As Ms Giddings said, Doctors for Assisted Dying Choice represents many hundreds of doctors in Australia and there are more than 100 names attached to that letter.

Our bill protects the vulnerable in every provision. It is also very similar, as Ms Giddings pointed out, to the Dying with Dignity framework introduced in Canada in 2016, which is supported by the Canadian Medical Association.

Voluntary assisted dying is now legal in 15 jurisdictions globally and quality evidence tells those of us prepared to listen - those of us with open minds on this issue, who put people first - that the laws operating in these jurisdictions for regulated, monitored, doctor-provided voluntary assisted dying in restricted circumstances are safe, responsible and valued. The laws are meeting the needs of some people at their end of their lives who are experiencing terrible suffering that will only effectively end with their deaths. The laws are principles-based, reflecting respect for competent adults and their doctors making voluntary informed choices. They also address what are serious deficiencies in our current laws and resulting medical practices which are inconsistent, ineffective and causing harm.

Some of the correspondence to members of parliament talks about the sanctity of human life, but I have to say the argument in the way it is put in opposition to this bill confounds and angers me. Where does compassion for the desperately suffering come into this argument? I will read to the House an email that arrived late yesterday from a person who lives in southern Tasmania who I will not identify because they have asked me not to release their name in this House. It says:

My husband died on 27 July 2001, five and half years after being diagnosed with cancer of the larynx. Just weeks later his larynx was removed together with a section of his oesophagus, which was also found to be affected. As the cancer steadily spread during the next five years and the intensity of treatment progressed my husband's previously robust enjoyment of life gave way to constant and intense pain during which he often battled hard to maintain to crumbling dignity.

Yes, there were periods of ease during that time but only in a relative sense. Short periods when the skin on his neck at the site of the surgery and subsequent radiology healed over. Blessed relief, albeit brief. Periods when medication to ease the intense pain of swallowing helped but that also didn't ever last long. The pain of swallowing was intense.

Sixteen years later I am still haunted by the memory of his body tensing, arms pushing down on the arms of his chair, lifting his body as it contorted with the pain of each swallow, and we swallow a lot of times each day. He had six months of palliative care with regular doctor calls and daily visits by the nurses who monitored his care. Wonderful, wonderful people.

Would my husband have ended that suffering if he had the chance? I have no doubt of that whatsoever. I am aware of two occasions when he asked outright if he could be given something to end the pain. No, that was not possible, we were told. Adjustments to medication but no permanent relief.

My husband bore his pain with amazing strength and humour but as to loss of dignity, what dignity is there to be found sitting in a pool of faeces in great distress, as I found him one day when I returned from shopping, no longer able to get to the toilet unaided or even to wipe his own backside. An uncomfortable six-day bout of constipation had ended with an explosive rush in which he had to sit

until I got home. That is just one of many, many examples. Hard, even at home with a close knit family who loved him very much. Soul destroying in public.

That is one poignant and distressing story. It is not the only story of people who are put in the most terrible, undignified situations as a result of their illness.

I also want to address some people in this place who are of the Christian faith and because of their faith, in many ways, they are opposed to the principle of assisted dying. I read a little bit from a brochure put out by the Christians Supporting Choice for Voluntary Euthanasia. It does say some quite enlightening things.

Mr Hidding - How do you know he is even a Christian?

Ms O'CONNOR - Well, Christians for Euthanasia. There is a series of contacts here. Are you saying it is not a legitimate organisation?

Mr Hidding - Have you checked them out?

Ms O'CONNOR - I Googled them. There is an organisation that is well known, Christians Supporting Choice for Voluntary Euthanasia, and has been active in this country for some time and they say -

Individuals suffering from a terminal or hopeless illness should have the right to choose a quick, peaceful and dignified death if that is their wish. To deny this is to deny Christian love and compassion. The moral case of legalising voluntary euthanasia is based on three principles: Respect for individual autonomy, our right to make decisions that are primarily our own concern; compassion for those who are suffering with no prospect of relief; and concern for the dignity of the person and his or her quality of life.

The sanctity of life arguments, the risk to vulnerable people arguments wear thin in the face of people suffering incurable, irreversible, painful medical conditions that cannot be relieved by palliation, and who are having their suffering prolonged by a system that is failing them. They are made vulnerable by their lack of choice, the denial of their autonomy. They lose their dignity, their choices are taken away and some feel they have no choice but to make the most terrible and the saddest choice; they choose suicide.

As Ms Giddings pointed out, in evidence to the recent Victorian inquiry into assisted dying, the State's Coroner John Olle revealed that between 2009 and 2012, 240 Victorians who were approaching death had committed suicide. Close to tears, he spoke of a 90-year-old man diagnosed with cancer so desperate to end his suffering that he tried to take his life with a nail gun. It is unacceptable.

I also acknowledge the presence in the Chamber today of Nica Cordova and her son, Gideon. I want to share correspondence with the House that Nica has sent through to all members. This is for those who would vote against this legislation because they say they support voluntary assisted dying in principle, but not this legislation. This is to speak to those members who might suggest this goes off to a parliamentary committee into the political never-never and we know that would be an excuse for not making a decision today on behalf of our constituents. Ms Cordova says -

In 2009 my late husband, dying of motor neurone disease, added his support to the 2009 bill. He was disappointed that it was sidelined to a committee of inquiry.

I sat on that committee and it was a highly politicised committee of inquiry. It is highly regrettable that it became so politicised. Relief for those with unrelievable and intolerable suffering was

delayed. The 2013 bill was also denied at the second reading stage, so delay in full consultation continues. It is hard to develop a bill that would satisfy parliamentarians when full discussion of clauses has yet to take place. I humbly ask that parliament allow this bill to go forward to the next stage. The public at large can have all the clauses discussed in detail so that this bill can, in all conscience, be thoroughly debated. A committee of inquiry is unable to do this.

We cannot shy away from the truth here. We cannot pretend palliative care, for all its immense medical value and capacity to relieve provides all the answers, it simply does not. That is acknowledged by medical professionals and the wider community.

The AMA's position statement is a shift from the position the organisation has taken in the past. They make an important acknowledgement of where the power and the responsibility in relation to this reform lies. It lies with the parliaments of Australia and today it lies with us. The AMA position statement says -

- 3.3 The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.
- 3.4 If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect -
 - all doctors acting within the law;
 - vulnerable patients - such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
 - patients and doctors who do not want to participate; and
 - the functioning of the health system as a whole.

The statement says -

- 3.5 Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.

I could not agree more. I was very disappointed to see a member of the Australian Medical Association on ABC News last night putting a farcical argument that the provisions of this legislation could potentially allow someone with profound acne to request an access the provisions of this bill. That is simply untrue. Unfortunately, the AMA did not respond to our correspondence - the letter that Ms Giddings and I wrote. The doctor who appeared on the news last night did not get in touch with people who understood the provisions of this bill to seek clarification, as you might expect in this case if he were so worried. The AMA did not offer us a briefing or come to talk to us about the legislation. The briefing was given only to the Liberal Party room. That is partisan and it is unacceptable.

Mr Ferguson - Every member was invited.

Ms O'CONNOR - I certainly do not remember receiving an invitation.

Mr Hidding - It was the only room available too.

Ms O'CONNOR - Okay.

Madam Speaker, what we need to acknowledge is that involuntary euthanasia is happening every day in this country. The data is very clear. I want to talk briefly about my dad, Shane O'Connor, and I thought very carefully about whether to talk about such a personal and intimate matter, and I decided not to. Then when I was writing my speech for today and looking at the data, and thinking about the fact of the involuntary euthanasia that happens in medical care settings every day in Australia, I decided to tell a short story of my father's life and very recent death.

Madam Speaker, this is the statistical context. Ms Ogilvie, I hope you listen too. The 1997 *Medical Journal of Australia* paper, 'End Of Life Decisions in Australian Medical Practice', found that in 30 per cent of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient's life, of which 4 per cent were in response to a direct request from the patient. The study compared Australia's medical end-of-life decisions with that of the Netherlands, and found that Australia had a significantly higher rate of intentional ending of life without the patient's consent, both through the administration of drugs and by withholding treatment than the Netherlands. In 22.5 per cent of all Australian deaths, doctors withheld or withdrew treatment without the patient's explicit request, with the explicit intention of ending life and to relieve suffering. Remember this is the esteemed *Medical Journal of Australia*. Never forget that compassion, a desire to see an end to suffering, is the driver in these decisions that doctors make.

I knew and loved my dad for 50 years. He was 78 when he died, empathetic, but very tough, fiercely intelligent; did not suffer fools. He was a former ABC press gallery journalist and foreign correspondent who received a distinguished Australian Service Medal and the Vietnam Logistic and Support Medal for his reporting in Vietnam during the war.

I was blessed to have been able to look into my dad's eyes before he died and tell him how much I love him and to thank him for all that he gave me as his daughter. I thanked him in that very brief window of hospital days before he was sedated into pharmacological oblivion. My father died in Brisbane the Sunday before last, six days after he went into the palliative care ward, a month to the day after they discovered the melanoma cut out of him four years ago had in fact got him in the end.

I tell this story not because I think any medical professional treating my father did the wrong thing. They were acting to alleviate his suffering. The decision to ramp up the morphine did, however, shorten his life and it was made without his consent. I do not know what dad would have said if given a choice, but he was not asked, primarily because a year ago he was diagnosed with dementia.

This is a story that is repeated every single day in this country. It is doctors who are making these decisions, not patients. In one way of looking at it, doctors play god with people's lives every single day, and in doing so, as we know, because we have the letter from [David Gunson SC](#) they expose themselves potentially to a charge of murder. I am very happy to provide that letter to members of the House.

Our bill protects doctors, medical professionals and patients. It protects people suffering unrelievable agony as a result of their diagnosed illness that will lead to their death. They deserve to have access to safe dignified choices at the end of their lives. This reform is long overdue. It is our hope that elected representatives from across the political spectrum will put their constituents first and support a safe, legal framework for dying with dignity in Tasmania. They will have strong public support if they do.

I thought I might end with a poem. This is the poem that my little sister, Kate, read out at dad's wake, but it is something for us to think about today. It is a poem that is written by Edmund Vance Cooke:

Did you tackle that trouble that came your way

With a resolute heart and cheerful?

Or hide your face from the light of day

With a craven soul and fearful?

Oh, a trouble's a ton, or a trouble's an ounce,

Or a trouble is what you make it,

And it isn't the fact that you're hurt that counts,

But only how did you take it?

You are beaten to earth? Well, well, what's that?

Come up with a smiling face.

It's nothing against you to fall down flat,

But to lie there - that's disgrace.

The harder you're thrown, why the higher you bounce;

Be proud of your blackened eye!

It isn't the fact that you're licked that counts;

It's how did you fight and why?

And though you be done to the death, what then?

If you battled the best you could;

If you played your part in the world of men,

Why, the Critic will call it good.

Death comes with a crawl, or comes with a pounce,

And whether he's slow or spry,

It isn't the fact that you're dead that counts,

But only, how did you die?

Madam Speaker, I commend the bill to the House.

[12.55 p.m.]

Mr FERGUSON (Bass - Minister for Health) - Madam Speaker, I am happy to participate in this debate and acknowledge that before us today is an issue of life and death. Who could be unaffected by any story of tragedy and sadness, particularly when it affects people who we love and care about. Let us have a debate today that does not ever assert that a member who does not agree with the conclusion that the previous two speakers come to means that any of us is less compassionate for our fellow human beings.

As I have said once before in a similar debate a number of years ago in this House, I wish we could pass a law that would end suffering. I wish we could pass a law that would put away the sadness of sickness, injury and disability. We cannot and we must therefore deal with our fellow human beings, fellow Tasmanians, in the most compassionate way we can, understanding that when you take that momentous step of interrupting a law, which has served us for many hundreds of years of do not kill, you need to make a case. You need to prove beyond doubt that even if members were to agree that that is the way to go, that you have guaranteed that your approach to interfere with the laws of murder, manslaughter and assisting a suicide is failsafe.

As rightly as it is, this is a conscience vote and speakers for and against this bill, all of us, need to be able to listen to each other with respect and consideration. It is an issue that largely, but not entirely, transcends where we come from as members of political parties. I have already, in just an hour, heard some compelling stuff. Some compelling statements, some compelling stories, but they have not made the case to change the law, which is that you cannot interfere with the protection of taking one life by another.

There will also be compelling arguments during our debate today from members who have come to a different view to show why this is, despite whatever good intentions has motivated its writing, a dangerous bill. It will create a different group of cruel tragedies to the ones whose stories have already been told.

In the time that I have served as Health minister we have focused as much as we can on improving end of life palliative care. This is Palliative Care Week and we are talking about a death bill. I have also spoken about the need to do more to prevent suicide in Tasmania, the great silent tragedy that has affected every member of this House and the majority of members of the Tasmanian family. We have all been hit hard by suicide in a different way.

We have spent three years talking. In my own language and in government documents we have said every suicide is one too many. Every one of them. Yet before us today is a bill that would sanction suicide. It has been put to me if there is suicide option for the oldies, what about the young ones who are going through intolerable pain, existential, personal pain? Do they get access? Would any one of us encourage that person, that young person to take that horrible step? I am sure we would not. I am

certain of it. I see some people shaking their heads, and yet the bill potentially would permit it and sanction it.

There is a different group of cruel tragedies that maybe we need to be mindful of. I believe in my heart that every suicide, including the ones whose stories have been told already today, are tragedies and they are one too many. We do have a clear and simple law against the taking of human life. There are no nuances, there are no ifs, buts, maybes - only defences. There are no provisos for particular circumstances because it is a solid protection.

Today, Ms Giddings for the second time and Ms O'Connor for the third, are promoting a bill that would change this fundamental protection. They are seeking to change the laws around helping someone to kill themselves through suicide, the laws that protect each and every one of us.

Sitting suspended from 1 p.m. to 2.30 p.m.

4. House of Assembly – Wednesday, 24th May 2017

VOLUNTARY ASSISTED DYING BILL 2016 (No. 73)

Second Reading

Resumed from above.

Mr FERGUSON (Bass - Minister for Health) - Madam Speaker, before the break I was saying the bill attempts to change the laws around helping someone to kill themselves and the laws that protect our fellow Tasmanians against murder and manslaughter. If anybody is finding that strong or confronting language, you have spent too long hiding behind euphemism. There is a raft of gentle phrases and lines that have been crafted, I think deliberately, to steer the mind away from the issues that are at the heart of this bill.

The reality is manslaughter, suicide and murder. But the words we hear from those promoting this bill now and in the past, have been euthanasia, dying with dignity or the new term, voluntary assisted dying. These words are designed to cover-up and hide the awful truth of what this bill really is trying to change and from whatever good motivation that may be.

We all agree it is a matter of life and death and if we cannot strip away the euphemistic language and discuss the reality of the matter then it will not be an honest debate and the public interest would not be served.

I ask those promoting this bill to be truly frank and honest in their descriptions, and for those listening to the debate today, if or when you hear those euphemisms, you need to remind yourself that the real words, however distasteful they are, are mercy killing and assisted suicide by a doctor.

It is natural to think about our own future, to think of retirement and then beyond to old age. Thoughts can then turn to a grimmer picture. Elderly, dying from a terminal illness, perhaps mentally diminished, in great pain and with the 'indignity' of needing help with simple tasks and personal hygiene. Even if our loved ones would love us all the same, no-one likes to imagine life becoming like that. Surely this person should be allowed to die with dignity, so the case goes.

I understand there is a degree of community support for that principle, as I have described it, of euthanasia in this situation, even if there is no thought given to protecting the community interest, which is not the Tasmanian person's job. That is our job.

Let us see what else the bill would deal with. For example, who knew in this bill, an 18-year-old girl with a non-terminal illness, could choose to suicide with medical help. We are talking about someone my daughter's age. Who knew in this bill a 43-year-old person, going through a cancer journey, with a high prospect of successful treatment, could choose active euthanasia instead of continuing with treatment and have their life taken with the permission and involvement of the same cancer specialist and GP who are supposed to be committed to restoring him to full health and a normal life, on balance.

Don't like it? This is what the bill contains. I am not talking about withdrawal of treatment - which is everyone's right. I am not even talking about double effect. We are looking at active euthanasia or assisted suicide of someone my age.

Going back briefly to that more extreme scenario which I described, that sick, painful, terminally ill person. They can and ought to be able to die with dignity and should always be supported in that. To interfere in the natural process of dying against the person's will is both medically unethical and already completely illegal. A person has the legal right, right now, to not be pushed through heroic medical interventions that artificially extend life or which are futile, against their wish. For that wish and for those rights to be respected, they need to be understood and known. This points to the need to better educate and encourage advance care directives or advance care planning in Tasmania, something others are also very interested in, and if time permits I will come back to.

For the third time in eight years in this parliament, taking into account all the previous debates which in each case identified major problems with each bill, the question for today's MPs wondering what to do is this: have Ms Giddings and Ms O'Connor got it right this time? After all, they have admitted the bill has changed. Is it guaranteed fail safe? Where is their proof? After 20 years of talking about euthanasia in Tasmania and three separate revisions to the various bills, is there absolute proof that vulnerable, older, sicker, disabled, mentally ill or people just tired of living, will be protected? Remember, this is a bill of life and death, and that is irreversible.

Some people like me have thought this through very carefully and conclude that it is not possible, even if you wanted one, to come up with a guaranteed fail-safe law. If I may say, reflecting on some earlier comments today, it is not helpful to pigeonhole any members of this House, or me, because I am a follower of Christ, imperfectly I add. I have looked at this, I think in many cases with more of an open mind and objectivity than those who reject belief in spiritual, moral absolutes. I am aware of the usual demeaning of those Tasmanians who do not believe such a mythical and perfect assisted suicide law is a good idea. Remember, anyone with either a Christian upbringing who believes in the commandment 'do not kill', or a person with a secular ethical conviction on the inherent human right to life, both equally have the right to that public policy position and they have the right to argue it for the state of Tasmania.

We cannot optimistically hope that just because good people feel passionately about this issue that they will somehow get it right, that they will make the proof and that they can come up with a guaranteed fail-safe bill. Some people do think that one day somehow that law will emerge, carefully designed, where a person suffering from intolerable pain and existential torment can freely choose, as an empowered individual, to end their life free of coercion, free of another person in their life with ulterior motives exploiting them, with a willing medical professional to make it happen cleanly and quickly, with all moral and ethical issues neatly solved and all doubts erased.

That is because we do not come to this debate only as MPs, but also as individuals. We are here in trust. We have a duty above party political interest to show wisdom in protecting the common interest whenever an individual interest, like this one, is being advanced, and fair enough too. Our job here is not just to express an opinion but to be mindful of the public interest. Are we as MPs interested in the interest of educated, financially independent, legally advised retirees who want to choose the timing and the manner of their own dignified death? I would say, yes. Yes, we should.

We should be interested in the interests of those people but I put forward today that this interest is not really at any risk in the debate on doctor assisted suicide. Thoughts turn instead to the welfare of the voiceless, the disabled, the weak, and those who are not in high society. They are also our interest, are they not? Like the elite, yes they are and I would further say this should be, in fact, our primary interest, indeed our greater interest because it is fairly obvious that in this elite debate they are at massive risk. They will be the new tragedies that I spoke about before the break, I guarantee it. I guarantee they will be the new tragedies and it does beg the question again; have they got it right this

time? Is it guaranteed fail-safe? Where is the proof? After all it is the third set of changes. Promises were made before, so why the changes? In a matter of life and death we have to be absolutely sure.

The movers of this bill are involved now for a third time. They have told us each time, no doubt in genuine self-belief, that this bill is safe and robust. They said that each time. The movers told Tasmanians to 'trust us'. Recently, effectively, euphemistically they have said, 'We have fixed it now, it has been thoroughly consulted, carefully designed', even making references to Parliamentary Counsel, 'trust us this time' and so the cycle continues.

The previous time this came before the House the Law Society cut it to pieces. As I remember, there were 19 major problems with the previous bill. Today's bill is based on the same one, supposedly with improvements. Imagine if members of that House, that parliament, had taken Mr McKim and Ms Giddings at their word and passed it into law. Tasmanians would have died against decency and the same is with us now. It is effectively the same bill except, in some cases, worse. They have taken out the terminal illness requirement.

Two promises have been made by the movers. First, Ms O'Connor in her opinion piece in the *Mercury* on 20 May, 'Our Bill protects the vulnerable in every provision.'. In the same newspaper on the same day, Ms Giddings said, 'I strongly believe that we have got the balance right and that it is a robust Bill with many checks and balances to protect vulnerable people.'

That is what they said. I expect they mean what they say.

Ms O'Connor - Do you want to go through any part of the legislation that you think fails to do that.

Madam SPEAKER - Order. I am not going to allow interjections when members had complete and utter silence for their contributions. It is not fair. We are on restricted time. If members do not like what is being said I suggest you leave.

Mr FERGUSON - In relation to Ms O'Connor's statement, 'Our Bill protects the vulnerable in every provision.', we only need to find one provision where that is not the case to prove Ms O'Connor's grand promise false. Non-terminal illnesses are now included. Do not mock the AMA when they interpret the criteria, as doctors themselves, reading the way you have constructed 'eligible medical condition' in clause 11. Serious but non-life threatening medical conditions, such as serious acne, which can be unbearable, such as osteoporosis, diabetes, arthritis or back pain fall into the new definition. They are irreversible medical conditions.

There is a situation of a provision where the vulnerable have not been protected. How about a second? How about the definition? It is related and based on the subjectivity of the person seeking that so-called voluntary assisted death. 'Intolerable for the person', further subjectivity that the person may have access to treatment and care that is not acceptable to the person, even though it might have been offered up by a qualified doctor with good hope.

I heard a reference to death tourism. Number 3, there is no requirement for either of the doctors to have ever met the requesting person. Couple that with the residency requirement, frighteningly open. Register to vote in Tasmania, rent a room or transfer your driver's licence to Tasmania; put those two together and you have death tourism: four times that Ms O'Connor's promise is broken.

Ms O'Connor - I disagree.

Mr FERGUSON - You may disagree, but the bill is yours. The bill leaves it open for doctors, number 5, to make a subjective judgment about deciding a person is eligible. The person's medical condition or treatment or complications depend on the subjective view of the person. It could only be

a matter of report from the person that the suffering is intolerable. Under this bill that is accepted, because you have based it on the person's view. That is five times you have failed to protect the vulnerable.

Number 6, there is no requirement that the specialised doctor is to be the person's treating doctor for any length of time or to have had any contact with the person's usual treating doctor. I do not feel very safe right now on behalf of a vulnerable person. The promise was made that they would be protected in every provision. That is six broken promises.

Number 7, on written requests there are a range of witnessing requirements for people who cannot write.

Ms O'Connor - According to you. You have already made up your mind.

Madam SPEAKER - Order. I am not going to allow interjections. We are going to have a respectful debate.

Mr FERGUSON - There is no clear requirement for a written request to have any witness. You have to think that through and you identify another provision where you have left it wide open for two trucks to drive through.

Number 8 is worse. A person making a written request may have the request completed and signed by a family member or a non-family beneficiary who would make a financial gain as a result of the person dying. This is so serious. If that is not the open door to elder abuse, I do not know what is. Eight broken promises.

Number 9, for people who need an interpreter; I wonder if we could agree there is potential vulnerability here. It does not have any minimum standard for that interpreter. There is no requirement for the interpreter to be independent from that person's situation. We have all seen the Swedish video of the interpreter listening to a victim of family violence, and the interpreter telling the police that everything is okay. If that is not an open door for family abuse, I do not know what is. An immoral death could follow.

I turn now to the promise made by Ms Giddings in that same newspaper edition. Ms Giddings' promise is a telltale sign that she is not really sure. Rather than focusing on the intended benefits of the legislation, she has identified the central problem that you have to deal with when you change the laws of murder, manslaughter and assisting suicide. She is admitting implicitly that however you try, some people are vulnerable. Bandaid protections, as they have attempted, will not change the fact that they are vulnerable. They will remain vulnerable.

The question for Ms Giddings and Ms O'Connor is, is it really so that those strong safeguards, those checks and balances make the bill robust and safe? If you open up those laws, you open up a range of possibilities and ways that people lose that basic protection and can have someone else take advantage of them or make assumptions about what is best for them.

Ms Giddings' problem is to find a work-around way to protect vulnerable people. Surely they are looking for a guarantee, not a balance. I demand a guaranteed failsafe. If these are missing from the debate, on their behalf we demand proof more than promises, more than trusting. You are asking this House to change the law. If just one Tasmanian gains medical help to needlessly kill themselves under the cover of the term 'dying with dignity' it is as tragic as any one of the weary souls who have ended their life in our beautiful state in the hopeless despair that life was no longer worth living, the pain inside was too great, and the hope was far too distant or had been extinguished.

If one Tasmanian has their life terminated at the hands of a doctor having felt like a burden to their children, worrying about the cost of aged care or swallowed the lie that life is only worth living in the absence of suffering, then it is just as wrong as the taking of an innocent life. Does the nice term 'voluntary assisted dying' satisfy any of these concerns and what is wrong here? For me, absolutely not.

Members of this parliament have already made promises about their intentions with this bill. I accept there is a range of opinion in the community, in my party, in this House. Maybe some have already reconciled themselves to the idea of sending a botched bill to an inquiry to be fixed. We have just had an inquiry by a committee of this House into end of life. It was not euthanasia, I accept that, but the Standing Committee on Community Development inquired into end of life and reported only last month. There were 26 recommendations, which have not been addressed by the Government or this House. I have views and insights into how the Government will be addressing those recommendations and today is not the time for me to represent that. Many of the problems with the current delivery of palliative health care relate to both law and medical practice - and perhaps resourcing. Rather than rubbishing the AMA for not inviting you to their briefing yesterday, which they did by email -

Ms O'Connor - When?

Mr FERGUSON - Yesterday morning at 7.30 a.m. to every one of the 25 members of this House.

Let me reflect for those who could not be there what was said to those Liberal and Labor members who did attend. First, we need solid, legally enforceable advance care planning legislation in Tasmania. It is about empowering the health consumer. Good on Ms Ogilvie, the member for Denison, for pushing that more than any. A mechanism for patients confronting end of life to take charge of and stipulate what medical interventions can and cannot occur to their bodies. Second, we need to improve palliative care because stories of people dying in intolerable pain are most likely to be people who did not receive the best level of pain management we are capable of and we have let them down. Third, doctors across Australia are asking every jurisdiction to make sure and to examine, and where required clarify, that doctors have protection where they are delivering pain management which has a double effect. Fourth, we need to ensure protection for doctors who do not provide futile treatment to patients in the fear they will be prosecuted for failing to save a life.

Have all those things happened? Were they ever pursued by previous health ministers, governments or premiers? I accept that some of these are complex matters. They require consultation, good legal advice and talking to the community.

It is very clear to me, especially in Palliative Care Week, that a thorough consideration of the Rylah inquiry's 26 recommendations and that four basic points being called for by Australia's doctors ought to be vigorously pursued and answers provided as to the way forward. I understand there is a move to push a bundle of issues, including potentially palliative care with euthanasia and assisted suicide, into a new inquiry. I will listen to this carefully when it is argued but I am doubtful it is really a constructive step in resolving whether this dangerous bill, this very dodgy bill - I have pointed out nine failures of a broken promise that it is safe - can be revived or repaired.

I heard Ms O'Connor's opinion that it is a political delaying tactic but I remain concerned that it is very doubtful this bill is repairable. Even if you really believed in its objects, even if you really wanted to find a way to deliver the goal of the bill, which is to allow a person to mercifully die and choose the timing of the end of their life. I am of the view that whether you support or oppose the principle of mercy killing or doctor-assisted suicide, this bill after three attempts is incapable of meeting the guarantee made by the movers that it is a robust bill with many checks and balances to

protect vulnerable people in every provision. They have failed a third time to prove it is guaranteed fail-safe, which in my mind demonstrates there is a structural problem with the intention to change the laws of murder, manslaughter and helping somebody to kill themselves.

[2.54 p.m.]

Ms WHITE (Lyons - Leader of the Opposition) - Madam Speaker, I thank very much Lara Giddings, the member for Franklin, and Cassy O'Connor, the member for Denison, for jointly sponsoring this bill and bringing it on for debate in the parliament today. I also acknowledge the tireless work of Margaret Sing, who is joining us for this debate in the gallery and her work with Dying with Dignity Tasmania, which has helped to inform the debate today.

I view this matter as a human rights issue. People are suffering cruel deaths, sometimes very lonely deaths, sometimes very traumatic deaths. As a society I sincerely believe that we must do better to alleviate the suffering and provide dignity and peace for people in their final stages of life. Individuals are the owners of their own bodies and should be allowed to make decisions about their own death.

This bill does not compel anybody to participate in an assisted death if they do not wish to. It is entirely voluntary. The involvement of medical professionals is entirely voluntary. The engagement of an individual with the process to progress an assisted death is only one that they can choose for themselves. This bill is about providing informed choice to people - a choice that they can make with the full support of the law; to choose to die in a way that eases their suffering and allows them to do so on their own terms.

It is important to consider what this bill is for as outlined in the first pages of the bill and I will read from those. It is an act -

to provide for medical assistance in specific and restricted circumstances to enable the voluntary death of competent adults with intolerable and unrelievable suffering due to advanced incurable and irreversible medical conditions, to provide for appropriate safeguards, monitoring and reporting, and for related purposes.

That is particularly relevant to point out in light of the contribution made by the member who spoke before I did.

The weight of evidence is convincing in favour of support for voluntary assisted dying in our community. Polling shows overwhelming support across Australia. Public opinion in support of doctor-assisted dying has been in the majority for more than four decades in Australia. Support was in the high 60 per cent in the 1980s, in the mid to high 70 per cent in the 1990s and in the low 80 per cent in 2000-2010.

There are many other jurisdictions which have models that have been in place in some instances as long as 20 years that work to provide a legal framework to enable somebody to die a peaceful death. This is not a first here in Tasmania. We have learnt through the work that has been done in many other jurisdictions. The colleagues who have joined together to introduce this bill have taken learnings from those other jurisdictions and presented a bill that is thoughtful, considered, robust and provides a strong legal framework to allow for voluntary assisted dying in this state.

I have never seen somebody die and I am grateful for that, but I am sure there will come a time when I do. I have read and I have heard a lot of stories and I have met families of those people who have watched a loved one die. Some of those instances have been very difficult, some have been not so difficult, but the stories I have heard where there has been enormous suffering, intolerable pain, reminds me why a bill like this is so important.

For those of you who were unable to join the rally on Parliament Lawns you missed a fabulous speech by a gentleman who sits in the gallery today, Gideon Cordova, who spoke so eloquently about his father, Robert. You spoke about your father being a fabulous storyteller and a very eloquent man. He would be so proud of you for the way you spoke today. The story you shared with us was incredibly moving. It was compassionate and it was so convincing in the arguments that you shared with all of those who joined us on the lawns today about why we need to have a legal framework in this state to allow people to choose to die with dignity if they want to choose to do that.

It is necessary to highlight again today that this is a voluntary system we are trying to establish a legal framework around to give people the choice. It is about giving them the opportunity to have that choice. With the speech that Gideon gave today he spoke about his father and the legal death his father had a choice of at that point in his life. He spoke about how his father could die legally by suffocating, through increased sedation, starvation or suicide. They were the four legal options available to his father as his motor neurone disease progressively got worse and worse, trapping him in his body.

Those sentiments struck me very powerfully because it is absolutely true. Those were the legal options Robert Cordova had at his disposal because of the laws we have in this state. He could suffocate, because unfortunately, as Gideon explained to the rally, 5 per cent of sufferers of MND suffocate to death because they can no longer swallow their own saliva, effectively choking. He could be sedated to a point where he passed by increasing medication such as morphine, for example. He could starve to death because he could no longer take in fluids or nutrition because he could not swallow, or he could suicide. They were the four legal options available to Robert Cordova and they are not unique to somebody like Robert in his situation.

Unfortunately there are many people suffering, just like he did, who are facing extraordinarily difficult decisions about their end of life and what that means, not just for them but their family and loved ones. Had members of this parliament all been able to join today for that rally to hear the story shared by Gideon, an incredibly powerful telling of his father's end-of-life experience, then perhaps there would be a shift in sentiment across the Chamber for those who are not convinced of the merits of this legislation. I want our society to be one that is kind and compassionate and where we do give people a choice about their death, because just like Robert Cordova and the story that Gideon shared today from the heart, that is unfortunately the story of countless Tasmanians and we need to do better.

This legislative framework provides a safe model for people who are suffering with pain and incurable conditions to make an informed decision about their end of life and about their death. The conditions set out in this bill for eligibility to access an assisted death are robust and protect against misuse and they do protect vulnerable people.

I will read clause 11 of the bill because it is very important for all members to be familiar with that and to understand who is eligible for accessing voluntary assisted dying legislation. Clause 11 says:

Eligible medical condition

(1) For the purposes of this Act, an eligible medical condition -

- (a) is the advanced stages of a serious incurable and irreversible medical condition, whether caused by illness, disease or injury, as diagnosed by a medical practitioner who has specialised qualifications, or experience, in diagnosing and treating the medical condition; and
- (b) the person's medical condition, or associated medical treatment, or complications resulting from the medical condition or treatment -
 - (i) is causing persistent suffering for the person that is intolerable for the person; and
 - (ii) there is no reasonably available medical treatment or palliative care option that would, having regard to both the treatment, and any consequence of the treatment, relieve the person's suffering in a manner that is acceptable to the person; and
- (c) there is no reasonable prospect of a permanent improvement in the person's medical condition.

It is very important because there were suggestions made by the speaker opposite that somebody who was undertaking cancer treatment at the age of 18 could choose to access this type of legislation. That would only be true in the circumstances where they met all the criteria as set out in the bill. It is not true to suggest that somebody could access this legislation to have an assisted death if they did not meet the robust criteria set out in this legislation and it is misleading to imply that could be the case.

There is comfort for people in knowing that the option of an assisted death is available to them, even though they do not take it up. They can plan for their death in a dignified and peaceful way, knowing that option is available to them. There are safeguards to protect against the legislation being misused. Clause 10 is about eligible requests and says:

- (1) For the purposes of this Act, an assisted dying request is an eligible request if the person making the assisted dying request -
 - (a) is an adult; and
 - (b) is a Tasmanian resident; and
 - (c) is competent; and
 - (d) is making the request voluntarily; and
 - (e) is diagnosed with an eligible medical condition; and
 - (f) complies with the relevant provisions of this Act.

This is a conscience vote in this parliament today. My vote today has been informed through conversations I have had with members of the Tasmanian community, through reading the evidence, the stories and the research. I will vote to support this bill because my fundamental belief is that individuals who meet the framework set out in this legislation should be supported by the law to

choose, if that is what they wish, to have a peaceful and dignified death. What right do any of us have to deny that to a fellow citizen?

[3.07 p.m.]

Mr JAENSCH (Braddon) - Madam Speaker, I believe every person here today, every person we represent and every person following this debate wants to relieve the suffering of people who are dying. We are all going to die. I believe we can all agree on these couple of starting facts and I think that Dying with Dignity, the AMA, palliative care providers, our churches and our families all agree on these things and they all want this for our people. We owe it all those people to leave here today with something decided that takes us closer to achieving that for more people more of the time.

There are many things that contribute to a person's comfort and dignity and sense of control when they are dying and their chances of having what I have learned is called a 'good death'. One of those things is early diagnosis of terminal or life-threatening conditions. Access to good advance care planning that means something, as early as possible, is another and gives people a sense of control over what is going to happen to them. Quality palliative care in all its forms and stages, again commencing as early as possible, is another, and pain management through medication and other techniques is another. For example, I have learnt about techniques of delaying or frustrating the formation of pain pathways in the brain that are part of the new evolving science of palliative care. It is a fascinating field and is changing all the time.

Importantly, another factor that contributes to a person's chances of experiencing a good death, on top of all these other things, is the character of that person, the skill of their carers, the love of their family, their faith and their values.

Equally, every person is unique. Every death is different and no treatment is perfect. There are gaps and deficiencies in every case and every stage of even the very best care and there always will be. I believe everyone involved in the care of people who are dying would agree, and there are people in Tasmania who are suffering terrible deaths, despite the best that we can do. It is our responsibility as a parliament and as a society to always try to do more.

I am convinced that a significant proportion of the Tasmanian community that we represent genuinely wants us to examine how, not if, we can offer safe, legal, voluntary assisted dying to address those cases of suffering that are beyond the capabilities of our best pain management to control: not as an alternative to good palliative care, but because we cannot offer anything better to relieve their suffering.

Importantly, for this debate when we understand this want properly we see that the request for assisted dying comes not because people want to die, but because they want to end their suffering and nothing else we can offer will do it for them. To me, and I am not a lawyer and you are, this sounds very much like the dilemma faced by the doctor providing pain management with the intent of relieving suffering, but the effect of also hastening death. No one wants death for the death; they want relief that only death can bring.

Regardless of our personal conscience, our faith or values or what we want for ourselves, as parliamentarians we need to respect that tragic reality and respond to it. The problem is this bill will not achieve that today for the very practical reason that it will not be passed. Not enough people will vote for it. It does not have the numbers.

Ms White - They haven't been tested yet; it is a bit early to say.

Ms O'Connor - You could actually do something about that if you support it.

Madam SPEAKER - Order.

Mr JAENSCH - Why? Why will this bill fail? I believe for the same reasons this bill and versions of it have failed before, and some new reasons. It is the 2017 version of a bill introduced in 2009 and then again in 2013 and most lately in 2016.

Ms O'Connor - It's very different from the 2009.

Madam SPEAKER - Order.

Mr JAENSCH - It was sent to a committee in 2009, which the proponents labelled as a cynical exercise. It has changed over time in its title and its key clauses and it has picked up, sensibly, developments from other places like Quebec as it has gone on.

Ms O'Connor - Canada, most specifically Canada.

Mr JAENSCH - Canada, and Quebec being part of Canada. It has become a little bit like grandpa's axe. It has had two new heads and three new handles, but it is the same axe and despite this it keeps failing to get up. It is not changing the minds or the votes of people who need to support it. It has a couple of other worrying features that diminish confidence in it for those who might otherwise be supportive.

One is the issue of drafting errors. I understand and we are told, and I believe because of the labelling on the thing that it has been to the Office of Parliamentary Counsel, but I am sure the version that we are looking at has not. There are upwards of 20 errors in this that make this bill hard to read and I am surprised that I am the first person here who has raised this today. This bill does not refer internally, consistently at all and it is hard work to follow through. That, to me, says this bill is not polished, not ready, not checked enough and that erodes confidence in this bill for me.

I also sense that there is an issue if not of mission creep then of communication between the proponents and their supporters and those who have been lobbying MPs like me. Over the last several weeks I have received hundreds and hundreds and hundreds of emails, letters, faxes and phone calls from people who are supporting this bill, and others who speak against it. Many of those supporting are asking me to support it because it is for people at the end of life with terminal illnesses and it will help them. Even those who follow the same formula for support in their own words, but the same phrasing and the same points are talking about this for reasons that are not reflected in the bill any more. This has become the biggest challenge for this bill. It has become the mission of getting voluntary assisted dying up as a principle. We have reworked the same vehicle for that several times over, to the point where some of the debate has become meaningless. Those who have championed it - and I take my hat off to them, honestly - have not been able to find yet, over the past three episodes of this evolving bill, a compelling new reason for successive parliaments to see it as something new and to take the arguments on in a new context.

The last time there was a real inquiry into the need and purpose of voluntary assisted dying in Tasmania was 20 years ago. I believe it is probably time to go back to what we all agree on, what we are trying to achieve and where this bill or elements of it fit, just as they did in Victoria recently and in Canada, which we are trying to emulate. On this basis I move -

The bill be amended by leaving out all the words after 'that' and inserting -

'That the bill be referred to the House of Assembly Standing Committee on Community Development to inquire into and report upon -

- (1) the provisions of the Voluntary Assisted Dying Bill (No. 73) of 2016;
- (2) other current initiatives aimed at relieving suffering at the end of life including consideration of -
 - (a) The House of Assembly Standing Committee on Community Development inquiry into Palliative Care 2017;
 - (b) the Victorian inquiry into End of Life Choices 2016;
 - (c) the Victorian Voluntary Assisted Dying Bill discussion paper 2017;
 - (d) the Australian Medical Association Position Statement on Euthanasia and Physician Assisted Suicide 2016;
 - (e) and contemporary approaches in other jurisdictions; and
 - (f) relevant Tasmanian legislation.
- (3) other matters incidental thereto.

And that the committee report by 23 November next.

I put this date in because I am advised by the Clerk that an amendment to be valid has to have a reporting date, and 23 November is the last sitting date of this parliament. This is a last chance with a sitting parliament to report on the work of this inquiry. However, I am also advised that this committee can report validly out of session and that that option is one that could be explored.

I also undertake that in the event this committee's work is not complete before the end of this term of parliament, and if I am part of the next parliament, I will move for this committee to be reconvened and for this inquiry to continue in the next term of parliament.

Madam SPEAKER - The member will need to table a copy of that amendment. While he is doing that, I remind members we are on time allocation and it does not allow for amendments.

Mr JAENSCH - This can be the Tasmanian equivalent of the Victorian and Canadian approaches and, as my colleague Michael Ferguson commented, we are not starting from scratch. The palliative care inquiry is current and has not yet been responded to. This gives us the opportunity to do what the proponents of this bill could have done, ideally might have done, earlier in the process to establish the context and connections required for voluntary assisted dying not only to become law but to work as part of our established care system. None of us would hope to see a voluntary assisted dying service or clinic that operates entirely separately from the rest of the care system that Tasmanians in need of this care would be travelling through. I cannot imagine someone would go to their GP, be referred to specialists, enter palliative care, do advance care planning, receive specialist treatment, go through pain management and then at some stage need to be trucked off site to a clinic in an alley to access assisted dying at the end of all that. I believe that for this to work and to become part of our care

system it needs to be born in the context of a joint mission as a state to reduce suffering and pain for people who are dying.

I believe that this process can be the circuit breaker this idea needs to give the community, the professions, interest groups and commentators the chance to examine it afresh as part of the mission to relieve suffering for people who are dying; to see where it fits in the continuum of care, not as part of a narrower and more detached focus on getting voluntary assisted dying up in Tasmania.

I admit it is a purely pragmatic approach to this debate. I think it is the best chance we have of leaving here today with the need and the work that has been invested in this bill recognised and available for Tasmanians to work with and support as part of a broader and more comprehensive approach to end of life care. I commend the amendment to the House.

[3.21 p.m.]

Ms DAWKINS (Bass) - Madam Speaker, on the amendment, we are deeply disappointed. We of course expected someone to bring up that it should go away again to another committee. We can go into committee here today. We can debate the clauses and we can make a decision as a House. We know this has not been done with any ill intent, but it is absolutely unnecessary. If you support the intent of this bill, which I believe you do, Mr Jaensch, we should have that debate here and now.

I rise with full support for the bill brought to the House by Ms O'Connor and Ms Giddings. This bill seeks to do these things: provide a last resort for terminally ill and chronically ill patients who are competent and whose competency can be attested to; to give clarity for medical practitioners through an independent registrar with the responsibility to maintain records and review all assisted deaths.

This bill also aims to give clarity for friends and family of the terminally and chronically ill, for example the case of Elizabeth Godfrey, whose son John was put on trial for assisting her suicide after three attempts. 'Elizabeth was a Christian all her life,' her son, Bill, wrote, 'But at 88 and suffering from an incurable condition, she made the decision to end her suffering'. As she was allergic to opiates, there was no end to her suffering but death, but with three failed attempts, she needed help, and that help landed her son in deep trouble.

This bill aims to eliminate this end of life trauma for the families of those for whom conventional medicine has no effect, and for whose pain and suffering is insurmountable. There is no doubt that this bill creates fear and causes extreme feelings in some, especially in some people of faith because the underlying basis for many faiths is the dictum that thou shalt not kill, but of course we do kill.

We kill in war. We kill in anger. We kill other animals for food and for recreation, and we kill ourselves. Medical professionals understand that with a doctrine of double effect, patients die when their pain is being relieved. Deep sedation at the end of life eases a slow and painful death, and in some instances, hurries death. Withdrawing life-supporting procedures also may cause death.

When advance care plans detail the kinds of treatment a person nearing end of life does or does not authorise, the end of life experience is often determined by these personal plans. Voluntary assisted dying, too, must be a personal decision. It is a compassionate approach to relieve the suffering of a person who is not going to get well, someone facing intolerable pain and anguish.

For someone who has the determination to make the decision for themselves that they want to control what happens to them at their end of life, understanding the moral question and not wanting to belittle that deep conviction, but even a Catholic Governor of California, when signing the End of Life Option Act said:

I do not know what I would do if I were ever dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill, and I would not deny this right to others.

This kind of premise seems to be the most universal in support of this legislation. We do not approach it with glee, it is a deeply sobering experience, researching VAD from the narratives of those who are demonstrating the need for this kind of legislation through the suffering of others, their loved ones, and in most cases their partners, parents, siblings or their children.

If we pass this legislation we will join seven US states and eight countries around the globe in the endeavour to give an individual control over their end of life. It is worth noting that the Netherlands, with the broadest VAD laws, has a rate of 3.4 per cent of deaths attributed to voluntary assisted dying. It is a statistic that supports the notion from Go Gentle Australia that in many cases where people sign up to voluntary assisted dying they die naturally. Even more appropriate and telling is the rate of voluntary assisted dying deaths in Oregon, the first American state to pass the law. It has been stable at less than 0.5 per cent of the population since the law was introduced in 1997. The Oregon law resembles this law quite closely and the number of patients dying this way has been static for 20 years. The slippery slope argument can be refuted by these statistics as the number and the circumstances in Oregon experience no additional consideration for mental health or other non-life-threatening conditions, more counselling, more open discussions around end of life care, better palliative care, more empowered people with more opinions, more options and a stronger sense of control.

This is also true of young people who find themselves in terrible circumstances where they are unexpectedly diagnosed with a life-limiting illness and they are desperate for some control in the final part of their lives. They want voluntary assisted dying as a safeguard, but when the time comes often do not use it because their deaths are managed and they have submitted to the process. The lengths those people will now go to in Australia to find a method of suicide can be heartbreaking, desperate and can consume some of the last months of their lives when they could and should be spending that time with their loved ones.

It was heartbreaking listening to some of the stories of these experiences from the mouths of the dying in Andrew Denton's series *Better Off Dead*. It was confronting and it was incredibly sad. After listening to that series, talking to friends and family I affirmed the opinion I already held that we should all be able to make our own end of life decisions and limit the pain and anguish to ourselves and to our loved ones when our death approaches. As a last resort, with the support of our community, our medical professionals, our closest friends and family and even in some instances our churches, if pain and suffering are too great we should be able to die on our own terms and not on the terms currently in place in Australia.

This is not a slight against the hard-working medical professionals, not a slight against our loved ones. This is an acknowledgement that our bodies belong to us and to no-one else and when that body fails irrevocably a compassionate and contemporary society should enable us to have the tools to end our own life on our own terms as we choose.

In a recent episode of *Q&A* an elderly audience member proclaimed 'bullshit' on a comment from a panel member when she was told she did not have the choice to make end of life decisions for herself. The panellist indicated that she was not entitled to make these kinds of decisions without the support of her community. This goes to the heart of this issue. Who should have the right to determine my end of life choices? If I have had two medical evaluations and there is an agreement that I am cognisant of the decision I am making and I am not being coerced, then I should be able to have the choice to end my own life if I am suffering enduring and unstoppable pain and anguish. I then make three requests, including one oral test with the provision for interpreters and sign language.

This bill establishes the kinds of safeguards that doctors have been arguing for, ensuring there are a number of doctors and specialists in physical and mental health who sign off on the agreement and I am not subject to any criminal charges. The bill removes the opportunity, as was included in the Canadian legislation, for voluntary assisted dying tourism by ensuring all those who avail themselves of this proposed legislation are Tasmanian residents, are competent and are acting on their own. This assessment is consistent with the contemporary practice and is already widely administered by a range of professional groups. The purpose of the test is not to determine whether the decision is right but to determine whether the person is able to apply the relevant information to make a decision that is in line with their preferences and values.

The information must be provided in a format that is accessible to the individual person. Oregon's death with dignity laws lead the way in the politically conservative country. We have seen that they can enact voluntary assisted dying laws and have done so with great effect and with very few opponents. Most religions do not support the voluntary assisted dying. It is worth noting there are some exceptions such as Christians supporting Choice for Voluntary Euthanasia.

Religion has proffered solutions to difficult questions regarding the human experiences through the ages, before the time of science and knowledge, when explaining the inexplicable through the notion of a 'Supreme Being' was used in benevolence but also used to entrench and control power. We can now answer those questions through science and many people are turning away from religion as the arbiter of knowledge. We appreciate the historical connection and the continued charitable work of the church but, for many of us, we do not need someone else to tell us what our morality should be. We define our own ethics and we endeavour to live by them in a personal way without an ancient tribe but with a tribe of our own making.

We understand some people of faith will rail against voluntary assisted dying legislation. It takes away power from the perceived supreme deity and puts in the hands of people. For a person with fundamentalist beliefs this is against God. However, not all people of religion feel this way and many find a way to include voluntary assisted dying in their sense of religion.

Ten per cent of all deaths in Australia are slow, undignified and painful. People lose autonomy, they fail to engage with the world, with people attempting to hoard medications to ease their pain by taking their own lives. This bill gives the option to the dying to either administer oneself and be assisted by a medical practitioner. There have been many arguments that elderly people fear being a burden but that is in fact the last reason given in Oregon. It is very rare to hear it and it is actively discouraged as a reason.

A most trusted voice in this debate has been of nurses, many of whom agree that voluntary assisted dying can be part of the palliative continuum but does not have to be so. As many nurses know, there is a point of no return when these kinds of decisions cannot be made. It is really important we engage with as many voices as we can in this debate. There are some in a disability advocacy space who have voiced serious concern about voluntary assisted dying laws and those living with a disability.

Stella Young was a fierce advocate for disabled people and we must honour her here with a mention. She spoke of how difficult this debate was for those who suffered daily the pain and distress of living with a disability and of discussions of life becoming unbearable with pain, resulting in the need for voluntary assisted dying laws that gave people the choice. For her, and for many like her, every day was filled with physical and emotional challenges. The kind of language used when discussing the degeneration of a disease and for those seeking voluntary assisted dying, the symptoms, the sorrow of loss of ability, spoke to the everyday challenges of disabled people.

The comments that cut through were those that suggested that life was not worth living as abilities were taken by illness. For the community struggling with some of these issues daily, it cut deep. If your life is not worth living, how is mine? This is a challenge. The language used cuts not to the detail of the law. If we ensure as this bill does that it is for people with terminal and chronic illnesses, and we consistently confirm this is a personal choice, there is no reason to suggest that voluntary assisted dying should demean the lives of people living with additional needs.

We must ensure that funding requirements for those with additional needs are met and that the language around disability is measured and respectful. We must ensure dignity starting with needs based education funding so that students entering school are supported through their education and through their entire life. The latest disability education snapshot has highlighted there is a long way to go in Tasmania to ensure all students entering school do so with sufficient funding to instigate study plans that allow for abilities and aspiration.

In this debate we must separate the needs of those with additional needs and the needs of those dying from a terminal illness or suffering chronic illness. We must not shy away from the circumstance where people who have lived with a disability also want to die with dignity. The measure here is competency. A person with a disability may, through this legislation, make their wish to die known. If they are unable to administer the drug themselves, a doctor could and should assist in that wish. That person, like the very one who would avail themselves of voluntary assisted dying, must be able to demonstrate competency and that they have not been coerced.

I will finish with a fragment of a letter from Peter McGoldrick. We all received this letter and many others but this is the one that stayed with me -

Earlier this year I had the privilege of caring for my wife during the final stages of her terminal illness. Her last few weeks were model 'best practice' palliative care for someone wanting to die at home. Despite limited mobility, she remained comfortable, conversant and lucid until a few days before she died. This all sounds wonderful.

I would now like to share the last couple of days of this 10 year journey. My wife's liver had failed, she could neither speak nor swallow and breathing was difficult. She could no longer move from her bed to use a commode and in fact defecated on herself the morning she died. High doses of opioid painkillers were keeping her calm and apparently comfortable. But this was hard to gauge as she could only communicate with grunts and groans. As long as she lay still she did not appear to be in any pain, but any lifting or forced movement was clearly very painful.

Her last audible spoken words (36 hours before the end) were, 'I just want to die'. The futility of those last two days will stay with me as long as I live.

I am proud to support this bill. Australians are demanding the right to die with dignity. I am a fierce support of voluntary assisted dying to be used in a measured and careful way which will still the fears of those who remain opposed.

[3.37 p.m.]

Ms OGILVIE (Denison) - Madam Speaker, I have a different perspective which I would like to share with everyone today. We have heard a lot of very emotional and very real and raw stories today. I will try to tell you mine without bursting into tears and it will be first time I have told it publicly.

I believe this bill should be debated forthwith. I am not supportive of the matter being put off to a committee. Some are nervous and are attempting to buy some time to dodge the question, or perhaps because they genuinely believe it is the way forward. For better or worse, we are in it now. We are having the conversation and we should see it through.

Today I wish to speak up for mothers of lost babies and deceased children. I have had a personal experience which, like many of the people who have written to me, changed my life and my perspective on death and dying. Yet, in the context of euthanasia, we very rarely hear from bereaved mothers and today, more than any day, is the right time to raise this.

My seven day old, full-term baby Violet, was born on 16 July. She died on 23 July. She lived a mere week but we had nine months together before that for which I am grateful. My daughter was born dying but my daughter died with dignity. I will be forever grateful for the care, hospitality, professionalism and strength of everyone at Calvary Hospital; the doctors, the nurses, the midwives, the staff. I think of my daughter every second of every minute of every day.

I am in the camp that says, 'Be robust in your decisions. Know when to stop treatment, using your head, heart and your mind. Provide as much medication as needed'. Caring and compassionate people must step forward, not back off when it comes to these things, but I also want to provide medical staff and medical providers with confidence that they are able to take these robust decisions within the context of our laws and in consultation with families, without the fear of negative consequences.

I want to ensure everyone is aware of the doctrine of double effect and its protective nature for end-of-life care and decision-making. The doctrine of double effect means that if you are caring for a dying person and your intention is to alleviate suffering and not to end that life, then you have no intent to kill and it keeps you outside the scope of the Criminal Code. That is the current legal position. It is here that people sometimes get a bit confused about what euthanasia is and what it is not. It is not euthanasia for a medical professional to provide medication to a dying person with the intention of alleviating suffering, even if the secondary effect is to shorten life. That is part of palliative care.

As you can imagine after an experience such as I have had, I went on a bit of mission, being a lawyer of 20 years' experience. I have reviewed the legislation of a number of Australian states and territories and international jurisdictions. I have also travelled to Holland and visited the euthanasia clinic in The Hague. I wanted to be open-minded and see what they had to say. They were lovely women, nurses, and very compassionate and sensible, but they have different laws. Amongst other questions, I asked two key questions at the Levenseindekliniek. The first one was: how did the national legislation come into being? The response was that nothing could be done until the doctors came on board. Without their support it cannot be delivered. The second question was: how does the right to die you have here fit within the legislative context of Holland? The answer was, 'There is no right to die. What we have is the compassionate gift of a doctor on request from a patient'. The doctor can always refuse. You do not have a right to have someone kill you, and that is what is at the heart of the problem with this. That is why you need the doctors on board if this is to succeed.

The AMA is opposed to euthanasia and until that changes a bill before us probably cannot become law. In fact, for any of this change to happen around euthanasia you need the doctors. Medical professionals are registered to practice on a national basis and it is my humble opinion that the issue of euthanasia on that level alone probably needs to be addressed at a national level. Each state and territory trying to do their own thing becomes quite difficult.

The bill before us anticipates a regime within which doctors are the providers and the scheme places substantial risk and responsibilities on those professionals, so you would want them on board with the legislation. The bill does not address the key provisions of the Tasmanian Criminal Code - that is our existing law - with relation to consent, duty to provide necessities, assault, homicide, hastening death and assisting suicide. All those things would need to be looked at. These are the provisions under our existing law that currently stop euthanasia from happening.

There are amendments to the Criminal Code that probably need to be considered, particularly for carers who may be inadvertently caught or in fear of being captured in the aiding provisions. I do not believe for a minute that Mr Godfrey should ever have been brought before the Supreme Court and I am glad my stepfather, Peter Underwood, Chief Justice, dealt with the matter sensibly.

I personally do not support euthanasia. Instead, I have prepared an alternative approach, which is the product of many years of work, which I hope will take our community forward on the issue of death and dying and will make Tasmania the leading light in compassionate end-of-life palliative care and clear decision-making, as such I hope it is a third-way approach.

I have drafted and tabled a bill, which is already in parliament and I will put a link to that up on my Facebook page for those who are part of that, but you can Google it and find it on the parliamentary website. The bill is called the Care and Consent to Medical Treatment Bill, which codifies our common law rights on a number of levels: of the patient on end-of-life decision-making to refuse or cease treatment at any time and thus choose the timing of their death; to provide proper protection for doctors by codifying the doctrine of double effect; to clarify and capture in legislation a patient's complete autonomy over their own body; to provide for dispute resolution and an escalation path for families and carers when it comes to complex end-of-life decisions; to set out for the first time a legislative framework for advance care directives; and to provide people with more certainty that their end-of-life decisions will be respected; to recognise that people die at all stages of life, from stillbirth through to old age, and let us never forget that; and to establish a commission-type leadership organisation to provide a structure in which all of the above can be delivered.

We have just completed a statewide palliative care inquiry and I was very grateful that we had a number of members of the community tell us their personal stories. I have received more stories around pain and the lack of pain management via email in the last couple of days than we received in that inquiry. I wonder why those two things are at such diverse ends of the spectrum. We wanted to hear those stories but they were not presented to the inquiry; we did not get the evidence. I take some hope and joy in the fact that the Care and Consent to Medical Treatment Bill triggered the inquiry.

I will turn very briefly to the bill before us today, which I think does have some deficiencies. The definitional section is very broad. How can you discriminate to restrict the application of this legislation to one category of terminally ill person? At law I really see no way of containing the legislation to one set of people. Why shouldn't my dying baby have access to euthanasia, if that is what we are going to legislate for in this state? That is a question I will leave hanging in the air.

I would also like to say to those who support euthanasia that I do understand your grief and concern and I have walked that path. I have walked in the shadow of my child's death every second of every minute of every day. When you are sitting here and you see me vaguing out, that is what I am thinking about.

This is the second free vote in which I have participated in this House. I hold dear to my heart the privilege of freedom of speech that we are accorded in this House. I want to make sure that this debate and what happens publicly in the public sphere afterwards and on social media is at all times respectful, because we have seen things happen when debates happen where there has been flow-on out in the public space that has not been helpful.

I encourage people to read my Care and Consent to Medical Treatment Bill which, I am pleased to say, has the support of the AMA. I will run through very briefly some of the key provisions, which I believe most of us would think are very sensible. The objects of the act are to make reforms relating to consent to medical treatment, including to allow for the provision of palliative care in accordance with proper standards to people who are dying, and to protect their right to refuse medical treatment.

It also deals with substitute decision-makers when you have someone who lacks the competence or ability to make their own decision or is too young. I was a substitute decision-maker for my child. Plenty of us in this House have been in that situation for elderly parents as well. I have had three close relatives pass away, including the Chief Justice, who dealt sensibly with Mr Godfrey's case.

The key reform is the codification of the common law principle of double effect. The clauses are clauses 14 and 15, and I will read clause 14 in which is the protection for medical practitioners:

A medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability for an act or omission done or made (a) with the consent of the patient or the patient's representative or without consent but in accordance with an authority conferred by this Act ...

So there is your substitute decision-maker:

(b) in good faith; and (c) in accordance with proper professional standards of medical practice, and (d) in order to preserve or improve the quality of life.

We know the patient is dying but they are trying to alleviate the pain and assist with quality of life in those last days. Clause 15 addresses the care of people who are dying and it says:

A medical practitioner responsible for the treatment or care of a patient, in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil and no criminal liability by administering medical treatment with the intention of relieving pain or distress (a) with the consent of the patient or the patient's representative; and (b) in good faith and without negligence; and -

even though an incidental effect of the treatment is to hasten the death of the patient.

That is our existing common law provision. That is our existing law and what we are doing, and what I am proposing we do, is move it into legislation so that people can know ahead of time, both as patients and medical providers, what their rights and responsibilities are.

We have handed down with Mrs Rylah's good chairmanship - thank you very much for how you guided that difficult inquiry - the palliative care report. Some key recommendations that spring to mind and resonate with me because of my personal experience which I am sure everybody would understand, I turn my mind to those. The recommendations:

That the Tasmanian government develop a comprehensive framework for palliative care to ensure that quality palliative care is available to all Tasmanians noting further likely increases in demand;

That the government creates a dedicated oversight body or authority to provide leadership;

That public education be provided;

That there is the establishment of a legislative basis for advance care plans.

I have been pushing this hard. There is no legislative basis at the moment so you cannot hold people to things. That is in my bill as well. Have a look at that.

That the Tasmanian Government review and assess the adequacy of the current provision of palliative care to infants and neonates.

Now we have achieved this there may no longer be a need for me to stay in parliament because that has been my mission. We want them to:

Increase support for parents with children in palliative care as well as for parents after their child has died.

These recommendations are in the report.

That the DHHS develops support programs and procedures for bereaved families and friends of palliative care patients.

I have given you my best reasoning for why I think a different course of action is a good course of action. I do not believe it is appropriate to send this to a committee. We ought to deal with it today and thank you for listening to me. It is very hard to tell a personal story. I got through it without crying which is great and it was nine years ago that that event fundamentally changed my life. That is why this issue is so important to me. I wish everyone luck with this debate.

[3.54 p.m.]

Mrs PETRUSMA (Franklin - Minister for Human Services) - Madam Speaker, I place on the record my thanks to everyone who has taken the time to email, phone and write me letters both for and against the Voluntary Assisted Dying Bill 2016.

I indicate upfront that I will be voting against the bill. Despite what I know are the best intentions of the member for Franklin, Ms Giddings, the Leader of the Greens, Ms O'Connor, and the member for Braddon, Mr Jaensch, for moving his amendment, I believe this bill still poses the same threats to the more vulnerable members of our society as was found by the House of Assembly Community Development Committee back in 1998, as well as when members of this House voted against the Dying with Dignity Bill in 2009 and the Voluntary Assisted Dying Bill in 2013.

This is because this bill still has quite a few major flaws as has been very well articulated by senior lecturers in law plus the Australian Medical Association. It is not possible in the short time I have available to outline them all. I will instead focus on a couple mainly to do with my portfolio responsibilities for children, disability and elder abuse, as well from my own personal experience as a registered nurse working in aged care, seeing many people die in aged care as well as close family and friends.

I am very concerned that this bill sends a mixed message especially to young people at risk of suicide as legally assisted suicide could encourage young people to think that suicide is now okay and a valid, legitimate option accepted in the community. I believe that this is incompatible with the society that seeks to protect those most vulnerable to suicide. This bill will create a confusing double standard for who should now be the focus of suicide prevention. For example, we have this Government's excellent body of work that has been done on the Tasmanian suicide prevention strategy and its companion documents *The Youth Suicide Prevention Plan for Tasmania* and *The Suicide Prevention Workforce Development and Training Plan for Tasmania* versus now who should be assisted to commit suicide through this bill that we are debating today.

I acknowledge that there are some safeguards in the bill. However, the fact that we need to have any stringent safeguards at all acknowledges the far greater risk that we have to the many who may be affected by such legislative changes, for example people with disability or the elderly, for the benefit of the few.

We know that experience in other countries such as the Netherlands, Belgium and Oregon show that over time watertight safeguards for assisted suicide cannot be legislated. Examples abound in these countries of breaches of the law, lives ended without consent, a lack of reporting and further watering down. For example, Belgium initially restricted access to people over 18 years of age, and then in 2014 brought in sweeping changes by extending assisted suicide to children. This is just one example of the slippery slope that we will embark on if we pass this legislation, especially as both Belgium and Netherlands are considering permitting assisted suicide for patients with dementia - Belgium for those in an unconscious state, and the Netherlands for those over 70 years who are simply tired of life and not even ill. Also in the Netherlands the way that doctors interpret the law changed. Such interpretations now include newborns with disabilities, patients with Alzheimers, and having a disability. If Australia has the same rate of deaths by assisted suicide as these other countries we can expect assisted suicide to soon be the sixth leading cause of death in Australia.

As a registered nurse who worked for many years in aged care and looked after countless people receiving palliative care, I am a passionate advocate for the need to ensure that we continue to research, use and promote world's best practice palliative care that is negating any need for assisted suicide. This is especially important as palliative care in the Netherlands is now well below best practice with doctors being quoted as saying that palliative care is now so inadequate in Holland that patients often ask for assisted suicide out of fear of dying in agony because care and pain relief is now so poor. According to Dr Els Borst, the former health minister and deputy prime minister who guided assisted suicide through the Dutch parliament, assisted suicide was brought in far too early and she has admitted that medical care for the terminally ill has declined since the law came into effect. She said that more should have been done legally to protect people who wanted to die a natural death.

As I said when we last debated the bill back in 2013, even though I have worked in aged care for many years I never ever had a resident ask me for assisted suicide, but I have had on too many occasions requests from family members to end the life of a vulnerable resident. This is often because the family cannot handle the process of watching their loved ones die. However, the person who is dying was themselves at peace with the process. Also, because death is something that no longer happens as part of everyday life in the family home as it did in the past, it is often the younger generation who cannot handle death and are themselves fearful of the process of dying, not the person who is dying. I have quite often had relatives say that it would be so much better if their mum or dad had assisted suicide, as they just seemed to sit there. Families do not appreciate the fact that their loved one was most often reminiscing and processing past events and seeking forgiveness, for example, which is an important process of dying that is so important for the elderly person to work through.

I sadly had one resident's child come up to me and say, 'The doctors reckon that dad only had a few more weeks to live and we are going overseas soon. Is there not anything that can be done about hurrying this along as we do not want dad dying and us having to come back from our holiday?' Madam Speaker, at the time I took a deep breath and suggested that maybe a better option was to consider saying their goodbyes before they went, as there was no pressure on them to feel that they had to come back. As it was, their father was still alive when they got back from overseas.

Another instance was where a gentleman was in his final days of dying and his family were, in their words, 'getting frustrated at the slow rate of dad's death,' as it was interfering with their employment as small business owners. Again I was asked, 'Could we not just hurry things along?' I sarcastically said to them, 'What do you want me to do, put a pillow over your father's face?', to which they seriously said to me, 'Can you do something about that?' I was horrified. The family failed to

appreciate that their father, even though he had only had a few more days left to live, was sitting up in bed joking with his brother who also lived in the same facility, and both were reminiscing about the good old days.

Based on these experiences and many more I could quote today, I fear that this legislation will create an atmosphere of uncertainty and distrust within Tasmania's aged care facilities, and cause some elderly residents to question the value of their lives, especially as around 52 per cent of all residents in aged care suffer from depression. They may worry about whether they will die with real dignity in aged care, which I know from my own personal experience that they do.

Tasmania is now rapidly moving to having more people aged over 65 years than children aged 0 to 14 years. With this rapidly ageing population, this bill does nothing to allay my fears that assisted suicide will especially engage with the lives of our most vulnerable, the elderly. I fear the elderly will get the message that if they want to do the right thing by society, they should cease being economic, financial and emotional burdens and opt for an early death for the greater good.

As the minister with responsibility for disability and elder abuse, I am also concerned that Tasmanians who are elderly or have a disability may feel pressured not to be a burden, or that their life is no longer worth living. As Dr Jeremy Pritchard, a senior lecturer in Tasmania's Faculty of Law, has found that there is much evidence that people with mental illness, dementia and disabilities have been disproportionately euthanised or assisted to kill themselves in Belgium, the Netherlands and Oregon, despite the presence of so-called safeguards. No amount of safeguards will adequately protect elderly Tasmanians against psychological abuse and from pressure being applied to them to opt for assisted suicide.

I see assisted suicide as the ultimate form of elder abuse.

This bill also infers that in the event of poor quality of life and intolerable suffering, people who are eligible should be able to seek assistance to end their lives. However, many disability advocates oppose assisted suicides on these grounds. Acclaimed British paralympian Tanni Grey-Thompson has described assisted suicide as:

... a chilling prospect for disabled people. Legalising it reinforces prejudice for people with disabilities and makes them afraid of a law that would offer a lesser standard of protection to seriously ill people than to others.

James McGaughey in his role as executive director of the Office of Protection and Advocacy for Persons with Disabilities in Connecticut said:

The disability rights movement is punctuated with stories of individuals who 'just wanted to die' before coming to realise they could still lead good, contributing lives.

Advocates worry that some people would never get to that realisation if assisted suicide became legal.

Here in Australia, Lives Worth Living, or LWL, is a network of senior disability rights advocates whose views on the bill emerge from a secular rights basis, as they are all people with disabilities. Some of their disabilities are lifelong and well advanced and would be included in the bill. LWL has a number of concerns with the bill, given the potential for abuse and perverse outcomes, especially as 23 per cent of Tasmanians have a disability, far higher than the national average of 19 per cent. Therefore people with disabilities in Tasmania may be at higher risk of perverse outcomes under this bill than in any other state in Australia.

Also the bill does not mention the UN Convention on the Rights of People with Disabilities, which has been ratified by Australia. Article 10 of the convention that people with disabilities strongly lobbied for, provides that states' parties reaffirm that every human being has an inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others. It is of concern to LWL that the opening sections of the bill do not mention the convention at all, nor stress equality of outcome for people with disability.

LWL also believes this bill opens the door to assisted suicide of people with disabilities because in section 11 there is a deep blurring between medical conditions and disability, which is made more obtuse rather than clarified within the bill. The bill says that eligibility includes persons with advanced stages of a serious incurable and irreversible medical condition, whether caused by illness, disease or injury; is causing persistent suffering for the person that is intolerable for the person; and there is no reasonable prospect of a permanent improvement in the person's medical condition. LWL makes the point that most disabilities are permanent, not able to be cured, are progressive and have stages, and that many people who acquire disabilities believe them to be intolerable, only to change their minds over time.

Many medical practitioners on this bill have made the point that for the very many people who suffer from a whole range of many chronic medical conditions from which so many of us will suffer in the future - for example, diabetes, heart ailments, pulmonary fibrosis, emphysema, Parkinson's disease, stroke, chronic fatigue, kidney disease, rheumatoid arthritis - if you are tired of life, tired of taking pills, are lonely and depressed, this legislation is now your passport to assisted suicide.

LWL also believes the bill opens the door to some disabilities which could be unacceptable at a point in time, but then can become bearable at a later point in time given the right supports. Many disabilities such as high-level spinal injury, multiple sclerosis, muscular dystrophy or motor neurone disease might fall into this category. The NDIS is being rolled out here in Tasmania and will offer more support for the 10 600 Tasmanians living with disability by June 2019. LWL believes the right supports and elimination of barriers, not assisted suicide, is the decent path to better lives for people with disability. As the NDIS will not be fully introduced for another two years, LWL believes this bill, in the absence of these supports under the NDIS for people with disability, may in the meantime be subjected to a raft of subtle, emotional, financial and personal pressures to end their lives. LWL is also concerned the bill creates a double standard in the treatment and interventions around ending one's life as the bill fails to mandate suicide prevention and other counselling which may identify other issues in people's lives which weigh in their decision.

LWL also has concerns about consent under the bill, especially for people with communication barriers. It is possible to imagine a situation where a person with a disability has no say at all, with only a family member who is familiar with that person's way of communicating being seen as the primary source of consent, which could open up perverse outcomes and exploitation. LWL believes that instead of this bill there needs to be more considered national work on a range of issues at the health disability interface and to harmonise these to avoid the risk of differing human rights outcomes based on where people live. LWL further believes the bill as it stands raises serious issues and risk for people with disability and they hope it is defeated.

Ben Mattlin in 'Suicide by Choice? Not So Fast', an article he wrote for the *New York Times* writes that as a good pro-choice liberal he ought to support assisted suicide laws, but as a lifelong person with disability he cannot. His problem ultimately is this - and I quote:

I have lived so close to death for so long that I know how thin and porous the border between coercion and free choice is, how easy it is for someone to inadvertently

influence you to feel devalued and hopeless - to pressure you ever so slightly but decidedly into being 'reasonable', to unburdening others, to 'letting go'.

Perhaps, as advocates contend, you can't understand why anyone would push for assisted suicide legislation until you have seen a loved one suffer. But you also can't truly conceive of the many subtle forces - invariably well-meaning, kindhearted, even gentle, yet as persuasive as a tsunami - that emerge when your physical autonomy is hopelessly compromised.

I was born with a congenital neuromuscular weakness called spinal muscular atrophy. I have never walked or stood or had much use of my hands. Roughly half the babies who exhibit symptoms, as I did, do not live past two. Not only did I survive but the progression of my disease slowed dramatically when I was about six years old, astounding doctors. Today, nearly 50, I am a husband, father, journalist and author.

Yet I am more fragile now than when I was in my infancy. No longer able to hold a pencil, I am writing this with a voice controlled computer. Every swallow of food, sometimes every breath can become a battle. And a few years ago when a surgical blunder put me into a coma from septic shock, the doctors seriously questioned whether it was worth trying to extend my life. My existence seemed pretty tenuous anyway, they figured. They did not know about my family, my career, my aspirations.

Fortunately they asked my wife, who knows exactly how I feel. She convinced them to proceed 'full code', as she has learned to say, to keep me alive using any and all means necessary.

From this I learned how easy it is to be perceived as someone whose quality of life is untenable, even or perhaps especially by doctors. Indeed I hear it from them all the time. 'How have you survived so long? Wow, you must put up with a lot!' even during routine office visits when all I have asked for is an antibiotic for a sinus infection. Strangers don't treat me this way but doctors feel entitled to render judgments and voice their opinions. To them I suppose I must represent a failure of their profession, which is short-sighted. I am more than my diagnosis and my prognosis.

This is but one of many visible forces of coercion. Others include that certain look of exhaustion in a loved one's eyes or the way nurses and friends sigh in your presence when you are zoned out in a hospital bed. All these can cast a dangerous cloud of depression upon even the most cheery of optimists, a situation clinicians might misread since to them it seems perfectly rational.

And in a sense it is rational given the dearth of alternatives. If nobody wants you at the party, why should you stay? Advocates of Death with Dignity laws who say the patients themselves should decide whether they should live or die are fantasizing. Who chooses suicide in a vacuum? We are inexorably affected by our immediate environment. The deck is stacked.

To be sure, there are noble intentions behind the 'assisted death' proposals but I can't help wondering why we are in such a hurry to ensure the right to die before we have done all we can to ensure that those of us with severe, untreatable, life-threatening conditions are given the same open-hearted welcome, the same open-minded respect and the same open-ended opportunities due everyone else.

Reports from Oregon show that around 48 per cent of the people who opted for assisted suicide identified being a burden on family, friends and caregivers as the major reason for requesting assisted suicide with eight out of 10 people being 65 years and older.

Research in Belgium has also shown that the elderly, particularly those over 80, were most likely to be the victims of euthanasia without their consent. Assisted suicide seems to be more about relieving other people of a burden than relieving unbearable or unrelievable suffering. If we justify killing people because they feel they are a burden on family, friends or caregivers due to a terminal illness, what messages are we giving to the disabled, elderly or the chronically ill who may need the care and support of others in order to function in daily life.

I am very concerned that this bill will open the door to increasing numbers of our senior Tasmanians being the victim of elder abuse. Elder abuse, as I said in my inaugural speech and on a number of times since, is one of the reasons I went into politics. From working in aged care I witnessed and heard heart wrenching stories of elder abuse. I investigated cases of elder abuse when working for the Department of Health and Ageing.

I became very sad, alarmed, distressed and concerned that as a society we do not give our seniors the care and respect they deserve in their final years. This concern has only increased with this bill. For elderly Tasmanians this bill, and the pressure to which they may be subjected to opt for an early death, has the potential to become the ultimate form of elder abuse.

As elected members of parliament we have an obligation to protect all members of the community who may be impacted by this legislation, especially our older citizens. Older people are more vulnerable because of their age, they feel more pressures, guilt and obligations, especially from a family member.

Time expired.

[4.14 p.m.]

Mr LLEWELLYN (Lyons) - Madam Speaker, I believe the motivation and the level of support within the community, which is undoubtedly there in expressing support for voluntary assisted dying, is understandable. We all face death and many fear death, if only because of the unknown, the physical fact of dying.

Those with faith may face that fear somewhat differently, but it is inevitable that we will all face death. There is a strong argument for the passage of this bill and there are equally strong arguments suggesting it is a step too far.

Many of the speeches I have listened to today have centred on horrific medical examples of bad deaths. Many ignore the advances in palliative care. As was mentioned a couple of times, last month we received a well researched and well consulted report with some 26 recommendations, of which a number recommended legislative change to address and improve our already excellent use of palliative care. I will quote a number of the recommendations in this report.

Recommendation 4 says:

That the Tasmanian Government establish a legislative basis for Advance Care Plans.

Recommendation 5 says:

The Tasmanian Government:

- investigate the regulation of outcome-based Advanced Care Plans to ensure their consistent application and effect;

- consider the issue of capacity and age in the creation of Advanced Care Plans;
- implement a secure register, where Advanced Care Plans can be lodged and which permits immediate access by authorised health care workers, including ambulance officers;
- provide education to the public, health workers and other relevant health professionals to increase awareness and use of Advanced Care Plans and the Register; and
- establish guidelines for medical practitioners to consult the register and consider a patient's Advanced Care Plan in treatment decisions.

Just one other, recommendation 17:

That the Tasmanian Government enact in legislation:

- the common law doctrine of double effect to strengthen the legal protection for those who provide end-of-life care; and
- the common law protection for doctors regarding withholding or withdrawing futile treatment. In this regard the Committee recommends Government give consideration to the South Australian *Consent to Medical Treatment and Medical Care Act 1995*.

I have been looking forward to recommendations coming forward with legislative change to enable, for example, a law around a consistent, outcome-based Advanced Care Plan process. The parliament could do no better than to take on board what my colleague, Madeleine Ogilvie has prepared in her private member's bill. It is a process that gives a sense of control and dignity for dying people and their loved ones. As the report I mentioned says:

People need to feel in control over their plans for their death, they need to feel in control over their treatment, they need to feel in control over where they are treated and ultimately they need to feel in control over their location at their time of death.

I am greatly concerned that the criticism of the 2013 bill expressed in the response from the Law Society, with the exception of two or three points that have been addressed, do not address the other issues of concern within that document. The issue about coercion is one of the most telling problems still around the bill. Section 39 - Offence to coerce or exert undue influence, which is unchanged in the new bill, the Law Society observed that there is a question as to how evidence will be obtained with respect to these offences when there is no facility for monitoring or compliance until the death of the person, the central witness, as it were, for an allegation of coercion. Obviously that person will be the person who is being assisted to die but they will not be available as a witness after death. These provisions offer very little protection against coercion or undue influence and that is of great concern.

Ms O'Connor - Rubbish.

Mr LLEWELLYN - Madam Speaker, you would expect in a debate like this that people would be very courteous and not interject. However, one of the proponents of the bill has been doing this.

I have a couple of other quotes, the first from a journalist, Angela Shanahan, who wrote in the *Australian* on 14 January 2017:

Last year I wrote about my brother who died of cancer. He suffered greatly and so did we who accompanied him into palliative care where he met his death. Later that year, another person in my life also died of cancer but in very different circumstances.

Carolyn had a matter-of-fact attitude to her diagnosis. It was terminal, inoperable and she didn't want to prolong her suffering with chemotherapy. So she made the difficult decision to go into palliative care in a place she loved on the coast. With her doctor's support she maintained her right to refuse treatment except for pain. She died with almost no pain in the best circumstances anyone could wish for.

She was religious and her decision was not supported by all her friends. Many of them thought she should 'fight it'. I was one who did support her. Everyone has the right to refuse treatment. In a terminal situation we have the right to meet death in our terms. Carolyn bravely, did just that.

And later on in that same article she makes the point that:

There is a case of Godelieva De Troyer who was euthanised in Belgium for no reason other than depression. I interviewed her son, Tom Mortier, who has become an anti-euthanasia campaigner because of his mother's case. He told me he was originally indifferent to the legalisation of euthanasia until her death. The most infuriating aspect for Mortier was that the doctor called it an 'act of love'.

Says Mortier: 'I loved my mother for over 30 years, and he never even bothered to tell me what he was planning to do!'

I also want to quote from Paul Kelly the Editor at Large in the *Australian*. These quotes are from an article on 1 October 2016. The quotes most identify with my position when considering this particular bill. First, he says that:

The justification for euthanasia lies in human rights, individual autonomy and relieving pain. All worthy ideas and that may prompt the question: why then is euthanasia still opposed by most nations, most medical professional bodies around the world and the Australian Medical Association?

The reason is not hard to find. It is because crossing the threshold to euthanasia is the ultimate step in medical, moral and social terms. A polity is never the same afterwards and society never the same. It changes forever the doctor-patient bond. It is because in brutal but honest terms more people will be put at risk by legislation than will be granted relief as beneficiaries.

The argument against euthanasia has endured for many years: it leads, on balance, to a less compassionate society that creates a new series of moral and practical hazards for itself. It is a disproportionate response to the real problem of patient pain that needs more care and money. It is because a society that legalises killing has to change fundamentally in terms of the ethics of its doctors, its medical ethos, its family relationships and its principles of human life. Belgium, having legalised euthanasia in 2002, offers a tragic picture of what can happen to a country just a few short years later.

Then later in the same article I quote:

In many ways this entire debate is about how to interpret love and care in the context of death. Hug the person you love. But realise this is also about deciding the degree of discretion doctors have dealing with death. It may be good for a doctor to follow a patient's wish for a lethal injection but that must be assessed against the total social impact of a regime that allows life to be terminated.

If we proceed then life will change, there will be a slippery slope, your relationship with your doctor will be different, the vulnerable will have reason to feel uneasy, the push to make euthanasia a right will be inevitable, the frail will feel obliged to volunteer and our values as a community will shift more quickly than you appreciate.

I will not be supporting the legislation before the House for the reasons that I have expressed and encapsulated in those quotes from Paul Kelly. I would like to see those recommendations in the palliative care report be facilitated into legislation as soon as possible.

[4.28 p.m.]

Mr ROCKLIFF (Braddon - Minister for Education and Training) - Madam Speaker, I welcome the opportunity to speak on the Voluntary Assisted Dying bill today. I commend my colleagues, Ms Giddings and Ms O'Connor, for bringing it forward. I understand it comes from a very good place and the reasons why they have articulated their support. It is a very heartfelt and a very real matter of importance for many Tasmanians. A number of them were out in a show of support for the legislation at lunchtime.

The end of life is something that we must all face. We recognise that and yet it is often a subject that we do not talk enough about or discuss with our families. Discussion about death and dying is very difficult for many people. I thank all the many members of our community who have emailed me on

this issue from all sides, particularly the people from various sides of this debate who have used their own words in their emails - not form emails but those who have taken the time to really think about this issue and personally reflect on how important this issue is to them.

I am often grateful for these debates because I believe they take us forward as a community and show the Tasmanian community, despite our differences of opinion on important social issues, that we can have very constructive debates irrespective of our political views. Considering what will be a relatively short contribution today, I have reflected on my contributions in the past on this, the Dying with Dignity Bill in 2009, and also the Voluntary Assisted Dying Bill in 2013. I have not supported both those pieces of legislation before, but it is always important to take stock and reflect on where your views and values have altered or changed over a period of time.

I have reflected on the process and manner of death and dying that are central to this debate as well. For some in the community it is gentle, timely, and for others it will sadly involve suffering and pain. Unlike a number, no doubt in this room today, I am in the privileged position of never having had to watch a loved one suffer in pain in death, and others have. It makes me reflect on how I have voted on this type of legislation in the past.

I am not saying my views might change some time in the future if I had that personal experience myself or a loved one. It must have an enormous impact on an individual when it comes to the manner in which someone they love passes away, particularly in tragic and painful circumstances. Everyone's views today, and I have listened to a number of contributions, are very valid, very personal, and this is an issue where there is not any wrong or right necessarily. People's views are personal to them and I respect everyone's views.

I understand though the desire for relief from such suffering for a person or loved one that people are caring for, must be undoubtedly very strong. I do have reservations about this legislation. I am not across the line yet on this. I struggle with it because there are good views or justified views either way. I have made a statement in previous debates that for me euthanasia really does go against the grain for me. It does not reflect my values in terms of that commitment I have to looking out for the more vulnerable in our community. I am grateful for the conversation and the debate. As always, something positive will change as a result of this.

Mr Llewellyn has talked about Mrs Rylah's report in terms of her palliative care report and the recommendations contained in that. I will talk about that in a short moment. Personally I am very open to Ms Ogilvie's advance care planning model, and I have spoken personally to Ms Ogilvie about this a number of years ago to get a better understanding of where she is coming from in terms of advance care planning.

I believe that any debate such as this needs to not only address the desire of those supporting voluntary euthanasia, but all end-of-life services such as respite and palliative care. It does give us an opportunity as a community, and as governments, political parties and parliamentarians to reflect on the services available to support compassionate end-of-life care. I have always used these debates as a member of the opposition, and unashamedly in government as well, to advocate for more and better palliative care in our community.

I note the 2017 report of Mrs Rylah and the recommendations in the report included increased public education, respite services for carers, a framework for palliative care or comprehensive advance care planning regulation of these advance care plans, and a dedicated oversight body. I empathise and agree largely with these recommendations. They highlight the importance of more government oversight of palliative care and better end-of-life planning for palliative care.

I am mindful also of our doctors and note the Australian Medical Association's position on this matter. I take their position very seriously. What impact such legislation would have on the patient-doctor relationship is something I think about a lot when I am thinking about my support or otherwise of the legislation before us today. Others may well have reflected on our doctors' position on this as well, particularly the fact that the Australian Medical Association believes doctors should not be involved in interventions that have as their primary intention the ending of a person's life. Again, that relationship between a doctor and patient: how much would that change as a result of this relationship? That question has not been answered.

Ms O'Connor - You wouldn't be so one-sided.

Mr ROCKLIFF - It has not been answered, though, Ms O'Connor, for me today.

Fundamentally I agree that end of life should be respected, regulated, planned for, very personal, designed around individuals for their needs, but I still cannot support voluntary assisted dying. I know that would disappoint the two movers and the co-sponsors of this legislation, who I know are passionate about this issue and I admire them for their passion, but for me it is not right. I recognise the majority of Tasmanians would not support my view. If you do a poll on euthanasia and voluntary assisted dying, most Tasmanians say they support voluntary assisted dying, but I do not concur with the view.

I worry about the vulnerable in our community and I have read the Paul Kelly article from 2016. That article resonated with me. I made sure I read that article when it was in the paper that day because I knew this legislation would come up at some point in time. It is the vulnerable I feel for most in this and that is where I fall in the debate. Are they protected enough? My view is they are not and you have not demonstrated that, despite your very reasonable and good intentions and attempts to do so. I cannot support the legislation as it is presented. It would take a lot of convincing for me to support such legislation.

I know my colleague, Mr Jaensch, made a very considered contribution. He has thought positively about his motion that he put forward about the legislation and I can see where Mr Jaensch is coming from to explore more research into this particular issue, but I am today voting on this bill alone. My colleague, Mr Jaensch, has some very honourable intentions, but I will not be supporting him today in what he has put forward, although I admire him for putting it forward.

For me today it will be about my view on the bill before us. Euthanasia still goes against the grain of my personal values. What I struggle with most is the fact that I have not walked in people's shoes who are suffering from a painful terminal illness or a family member as such. My views might change as a result of that experience, but today I will not be supporting the legislation.

[4.41 p.m.]

Ms O'BYRNE (Bass) - Madam Speaker, I appreciate the opportunity to rise on the Voluntary Assisted Dying Bill, but cannot commence without saying I would hope we had the maturity to address problems we have not experienced. There are a whole host of life experiences I have not had, but when required I form a view on those, so I am a little disappointed about that.

These are not easy debates and I appreciate the large amount of correspondence we have received on both sides of the debate. I have read those in support of the legislation, those who are not in support of the legislation, and those who have asked questions and I appreciate the passion that underlies them.

We are not now necessarily just addressing the bill. We are addressing the amendment that has been moved as well. We are addressing an amendment to send this matter to a committee, but I fundamentally think that such a decision lessens us.

We have, as members of parliament, an incredible honour to sit in this place and have the right that is denied to most people to cast our vote on this issue. It is not a vote that everyone in the community gets and it is one we are very fortunate to participate in. We should not squander that right or waste that privilege. We are here. We are all genuinely tested by the issues before us and we should stand and be counted. We should all have the courage of our convictions to vote for or against the legislation, not look for a way out because it makes us uncomfortable. We are all uncomfortable to be here, these are difficult things to talk about, but frankly it diminishes us when we do not stand up and take the responsibility that we all sought. We all sought to get elected and we all sought to sit in this space. There are rare opportunities for conscience votes in this parliament and when we have them we should be committed to them.

I also believe we are diminished when we use words of support for a bill or the principle or intent of the bill and then codify it with words such as 'just not now', 'just not this'. This bill deserves to be debated tonight through the Committee stage and deserves to be tested. For those such as the former speaker who are unsure and says he needs to be convinced, that Committee stage is a valuable opportunity to test whether the legislation meets the kinds of protections we all want to see. If it fails at the end of that then perhaps there are forms for the House, Mr Jaensch, to go to a committee. I believe it deserves the right to be heard tonight and we should stand up to the trust put in us by the Tasmanian people and be prepared to do that tonight. We should not be sending it to a committee. If it fails we can send it to some other kind of inquiry, but we should not do that yet.

There is not a person who has been in the gallery today, who stood outside today or who has written some incredibly passionate letters on both sides, who would not want to see us in this House today making a vote. I am, sadly, not surprised at the kind of mechanism of pushing something off and not dealing with it that is being used to undermine genuine debate on this bill. Those who were in the Chamber for the reproductive health bill would remember, members of the then opposition and then government having quite diverse views. There were those who totally did not support it and then there were those who said, 'I support decriminalisation, just not now, just not this'. There was even a member who stood in the House and said, 'I support it so much that I will bring exactly the same legislation to the House - just not now, just not this'. We saw it again with marriage equality with the original debate. There were those who were fundamentally opposed, those who agreed, but said, 'Just don't make us make a choice about it now'.

I have incredible respect for those people who, due to their faith and/or whatever story that they have come to, have consistently opposed this bill. They have genuinely been true their word and beliefs. I do not have those views of members who claim to support something but do not have the courage to vote in this House.

Conscience votes are really hard. There is not the protection of your party. There is no, 'I am sticking up for the minister, I am backing my shadow minister'. There is no protective element. You stand here alone as an individual and have to consider the view. It is a great test of us all as individual and we should not squib it. Our electors expect more of us and, frankly, we should expect more of ourselves. Sending this to a committee before fully debating it reflects poorly on us.

I have not found this debate easy and I know that surprises some people. I am passionately progressive, I am far left, I am a huge supporter of abortion law reform and pro-choice, but this one is different because we are dealing with adults, people who are living lives that none of us would want

to live. It is a much harder conversation to have. I have not come to this with total and utter support each time. I have participated in the debates before and they were hard as well.

We do not want to hurt anyone. We do not want anyone to be inadvertently poorly affected by legislation; none of us come here wanting to do that. We want to ensure the safety and protection of our vulnerable older people, and so we should. I genuinely believe this bill does provide that protection. It is carefully constructed and considered legislation that ensures people, in the most intolerable of conditions, are not forced to live lives of unimaginable pain and distress.

We all have personal stories, and it has been incredibly courageous of people to share them. I will not share mine but we all bring to this debate our own experiences. In all good conscience, I cannot be party to people's ongoing and unimaginable pain. I cannot be complicit in the agony of these people's lives, and I will not be. We have to recognise that no matter how wonderful our palliative care system is and how wonderful the advances in medical technology are, there are people who, regardless of what support they are given, continue to suffer pain. No matter what pain relief they are given, they are still in horrendous circumstances. These are the people who are so desperate that they ask us to stand up and allow them to make the choice about the end of their life.

The National Report on Patient Outcomes of March 2016 confirmed not all patients can have their pain relieved. The Canadian Supreme Court said that the only offer for those people is to be offered a cruel choice between an horrific death and desperate suicide. None of us want to be party to that, but all of us today are. All of us are currently complicit in the circumstances where people take their own lives because they are so desperately in pain. We need to think about that because many of us come to this House in the debate saying, 'I am not comfortable with making a decision that allow people to take their own lives', but by not making this decision we have to accept we are comfortable with those people being forced into suicide. That is a horrible thing to do and we have to remember that is the other side of this debate. We have to say we are comfortable with medical practitioners having to make very difficult decisions in the way they treat people in order to minimise the experiences they are in.

I was shocked when I read some of the work out of Victoria. The Coroner's Prevention Unit in Victoria looked at the number of people who take their own life. You say you do not want to tell your own stories but my friend's grandad managed to make it to the back shed where the shotgun was. That is our fault, too, because we are not giving those people a better way of ending the pain they are in.

I believe the bill does provide the protections required, and we want those protections. No patient is compelled to do this, no health service provider is compelled to assist a patient to die. It is a last resort option.

Under this legislation you have to have an eligible medical condition. You must have a serious, incurable and irreversible medical condition in its advanced stages, with no reasonable prospect of a permanent improvement in that person's medical condition. The condition must be causing such persistent suffering that it is intolerable for the person affected and there must be no reasonably available medical treatment or palliative care options that would relieve the person's suffering in a manner acceptable to the person. It will only allow an assisted death for eligible people who make persistent, consistent and voluntary requests. There are multiple checks to ensure it is made on a voluntary and informed basis.

Ms Giddings and Ms O'Connor have gone through those tests. I ask people to remember when we are voting on this bill today - and I do hope we have the chance to take it through the Committee stage and truly test it - we are not simply saying we do not want people to end their own lives. If we choose not to support this bill we are consigning people to ending their lives in misery, agony and pain, or at their own hand or the hand of their loved ones. That is not something this parliament should do.

[4.52 p.m.]

Mr BARNETT (Lyons - Minister for Resources) - Madam Speaker, all MPs in this place desire a more caring, compassionate and loving society where the frail, aged, disabled, sick and vulnerable are protected and supported.

The Voluntary Assisted Dying Bill 2016 is ill-conceived and, sadly, has a perverse effect, delivering a less caring, less compassionate and less loving society. It is a seriously flawed, inconsistent and ambiguous bill. It lacks adequate safeguards and is an expansionary version of the previously defeated 2013 bill. The first few words of the bill say it all: 'Be it enacted by His Excellency the Governor of Tasmania'. It is an obvious error and it all goes downhill from there.

The bill establishes a legislative shield, in my view, for selective homicide. The message this legislation sends to those suffering depression, mental illness, the aged, frail and vulnerable is, 'You are not valued and you are less equal than other Tasmanians'. In God's eyes we are all equal and worthy of love. This bill undermines the dignity that should be ascribed to each and every person. The bill also undermines all the good efforts in recent years to combat youth suicide and suicide more generally, especially in rural Tasmania.

The AMA opposed the bill for good reason. The founding ethic for every doctor based on thousands of years of tradition is 'do no harm' - sometimes referred to as the Hippocratic Oath. That ethic is demolished by this bill. Worse still, the bill compels certain doctors and health professionals to act in a certain way against their conscience. For example, clause 14 compels the medical professional to provide their patient with information on ending their life regardless of the doctor's own medical opinion or ethical position. This is an outrageous breach of the right to free speech, freedom to choose and freedom of conscience.

Let me now outline in greater detail the reasons I strongly oppose this bill.

Euthanasia in Australia is a failed experiment. Euthanasia has been tried in Australia and it has failed. More than 20 voluntary assisted dying bills have been presented and defeated since 1995 across this country, including two in Tasmania. When I was a senator I was for a time Deputy Chair of the Senate Committee on Legal and Constitutional Affairs. In 2008, the committee examined the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008. The bill, a private senator's bill, introduced by Senator Bob Brown, proposed the repeal of the Euthanasia Laws Act 1997, and allowed the Northern Territory, ACT and Norfolk Island to make legislation permitting voluntary euthanasia. It also proposed to revive the Northern Territory Rights of the Terminally Ill Act 1995. The committee received over 1800 submissions. Its findings were chilling. Of the seven deaths that occurred in the Northern Territory, four revealed prominent features of depression. Let me repeat, more than half of the deaths under that regime were accompanied by symptoms compatible with that of depression.

This observation comes from the Professor of Psychiatry at Cornell University, David Kissane, who was also Professor and Director of Palliative Medicine at the University of Melbourne during 1996 and 1997. He is arguably a leading authority on the operation of euthanasia in the Northern Territory, having published numerous articles documenting that experience. Based on his observations, he said:

The brief period of legalised euthanasia in Australia provided a useful window of opportunity to view the experience of such a social experiment. Despite considerable legislative effort to draft safe regulations that would protect the vulnerable, a review of the clinical accounts of patients that sought access to this legislation reveal blatant failure of the Act to achieve its purpose. Certainly, the gatekeeping roles designed by this Act failed to protect the depressed, the isolated and demoralised patients.

A sorry story indeed and a tragedy for a nation that prides itself on standing up for the underdog and those doing it tough. The Northern Territory's brief adventure with euthanasia was a tragic failure.

Experience from overseas jurisdictions which have legalised euthanasia assisted suicide show that meaningful and foolproof safeguards cannot be legislated. Examples from the Netherlands, Belgium and the United States consist of lives ended without consent, breaches of the law, and a lack of reporting. During Australia's brief flirtation with euthanasia in the Northern Territory, similar breaches were observed. Dr Philip Nitschke, pro-euthanasia advocate, admitted to such a breach and has subsequently been disbarred by the AMA as a medical professional.

The Northern Territory legislation proved no safeguards will ever eliminate the risk. It proves that mistakes can and are made, fatal mistakes. Wilful breaches can and have occurred. If the risk of getting it wrong was enough to justify the abolition of capital punishment in Tasmania in 1968, then surely the same risk would justify the rejection of this bill. The reality is certain. Some people will pay for the decision with their lives if euthanasia is legalised.

The original Dying with Dignity Bill 2009 and the Voluntary Assisted Dying Bill 2013, on which this most recent bill is purportedly based, only sought to allow euthanasia and assisted suicide in cases of terminal illness. The bill before us increases the field to include those suffering from serious, irreversible and incurable medical conditions - a vast expansion. Where does this leave people captured by this definition? Tasmanians with kidney disease, with diabetes, asthma, MS, lupus, epilepsy, autism, pulmonary emphysema, paraplegics, quadriplegics and many people with a disability.

The AMA Federal President representative, Dr Chris Moy, who we heard from a couple of days ago, said, 'The definition in this bill may include someone with severe acne. The category of killable people under this bill is vast.' As a person living with type 1 diabetes, legislation as loose as this puts a target on my head and the head of thousands of Tasmanians living with diabetes.

I am not alone in my concerns. Lives Worth Living is a network of senior disability rights advocates in Australia speaking out against assisted suicide. This is what they had to say -

This Bill is not confined to terminal illness and we believe opens the door to the euthanasia of people with disabilities.

Many disabilities such as a high level spinal injury, multiple sclerosis, muscular dystrophy or motor neurone disease might fall into this category. In the absence of supports for people with these disabilities this Bill is open to perverse outcomes and exploitation of vulnerable people.

HOPE, another nation-wide secular group opposing assisted suicide and also Right to Life Australia also pinpoints the breadth, perhaps unintended, of this clause. The Australian Christian Lobby in their contribution on the bill note:

Legitimising state approved killing by making death a 'choice' exposes vulnerable elderly people to indirect pressure to shorten their lives. Frail elderly people can often feel like they are a financial or emotional burden on their loved ones. In such cases vulnerable people could feel like they have a duty to end their lives.

If this is what the euthanasia lobby seek now what will they be asking in three, four or more years time?

Experiences overseas consistently show that euthanasia that is legalised has spread because it becomes inevitable. For example, during the original euthanasia debate in Belgium access was explicitly restricted to people aged 18 years or over on the grounds that the inclusion of children was 'deemed so controversial it would have threatened the approval of the Euthanasia Bill'. In 2014 an amendment was passed that allowed the euthanasia of minors. Most Tasmanians would reject euthanising children as an abhorrent concept.

Studies in the Netherlands, another early mover in legalising euthanasia, show that it is no longer the terminally ill with only weeks or months to live who make up the vast majority of those euthanased. Instead an increasing number of patients are seeking to end their lives because of psychiatric illness, dementia or accumulated age-related complaints.

Now, both the Netherlands and Belgium are considering increasing access to euthanasia to include dementia patients, for unconscious patients with advance care directives, and even people over 70 years who are not necessarily ill, but simply tired of life.

In some particularly disturbing Dutch cases, people are choosing death where the suffering consists of being old, lonely or bereaved. This should concern every right thinking and caring person in this place. It is naïve to think the same thing would not happen here. If passed, this bill puts us on the slippery slope to unthinkable abuse of the weak and the vulnerable.

Assisted suicide need not be the only solution for those suffering terminal or other illnesses. Recent advances in medical technology and pharmaceuticals has seen palliative treatments leap forward even in the last 10 years. These advances provide genuine and viable alternatives to end of life decision-making to the one sided view often espoused by supporters of assisted suicide. Experts in palliative care, oncology and related fields almost unanimously agreed that nearly all symptoms arising from physical pain at the end of life could now be managed.

It should not be lost on members that this bill is being debated during National Palliative Care Week, with this year's theme being 'You matter. Your care matters. Palliative care can make a difference'. An important message and reminder to those living with terminal or other illnesses is that they matter. The House of Assembly Standing Committee on Community Development recently reported on an inquiry into the state of palliative and end of life care. Several of the key recommendations of this inquiry, which was ably chaired by one of my colleagues, Joan Rylah - and congratulations, Joan, on a wonderful piece of work - revolved around the importance of palliative care and advance care plans. Thanks to Joan and all members of the committee for that report.

Advance care plans or directives are generally understood to be formal expressions of an individual's treatment wishes written or recorded by a person in anticipation of the person being in a state of incapacity, which is intended to have effect if the person actually becomes incapacitated. ACDs, which currently have no legislative basis in Tasmania apart from the common law, help protect people when they are at their most vulnerable, often having lost the ability of independent decision-making. I have been on the record as supporting ACDs for a number of years and hope to see solid action that will establish them as a common, even standard part of end of life planning.

I also commend my colleague, Madeleine Ogilvie, for her research and effort in drafting legislation addressing these issues. As members also know I have been a long-time advocate for improved palliative care services and remain honoured to be Motor Neurone Disease Australia Ambassador supporting people with MND and their families and standing up for better services to support this community.

If we are to be a society of care and compassion then surely we should be coming alongside those who are hurting rather than offering them a bleak and permanent quick fix to their problems. My concern and that of many others in Tasmania is that legalising euthanasia will be sending entirely the wrong message to vulnerable and hurting members of our community. Not only that but we run the risk of undermining the significant investment that has been made in supporting those with mental health issues and boosting suicide prevention by governments of all sides and levels. That funding support last year was \$8.5 billion, much of it from state governments, 36 per cent from the Australian government, 5 per cent from the private sector, but that investment is growing and it is very well supported.

In the words of Archbishop Julian Porteous in last Saturday's *Mercury*:

We cannot and should not overlook the strong message legalising assisted suicide would send to these very vulnerable individuals.

An insightful point, well made.

Again, these concerns are shared by others. Let me quote from the disability rights groups, Lives Worth Living. Lives Worth Living is concerned that the bill creates a double standard in the treatment and interventions around ending ones life based on disability.

Euthanasia is assisted suicide and as we read it the bill fails to mandate suicide prevention and other counselling which may identify other issues in people's lives which weigh in their decisions.

We should be helping those in need not sending them a message that suicide, in any form, is okay.

Legalising medical killing, as some describe it, will also fundamentally change the nature of medical care. For 2500 years, as I have indicated, our medical professionals have subscribed to the Hippocratic Oath to do no harm. Here in Australia the AMA say this:

The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of known medical benefit to a dying patient.

Thanks to the AMA for that contribution.

In terms of assisted suicide it gives greater opportunity for elder abuse. This is a serious concern and I know it has already been well made by my colleague, Jacquie Petrusma, during this debate. It speaks of the vulnerable who are facing end-of-life decisions where pain or other circumstances, sadly even family in some situations, can lead to expressed wishes or even decisions that are at odds with the fundamental desires of the person.

The Australian Law Reform Commission on Elder Abuse found that 4 per cent to 14 per cent of older Australians are abused most often by a close relative. A particular concern of the commission was early inheritance syndrome where a person, typically a child of the abused, obtained a power of attorney and embezzled the financial assets of the older person for themselves. Even in Tasmania the hotline set up in 2012 has already handled nearly 500 cases of abuse in less than two years. It would be naive to assume that the legalising suicide would not in a number of cases open opportunity for further lethal abuse of older Australians by unscrupulous children or heirs.

It also goes without saying that the difficulty in prosecuting such an action is immense given the one abused would be unable to tell their side of the story having ostensibly agreed to euthanasia.

In conclusion, I do not support the proposed amendment by my colleague, Roger Jaensch, member for Braddon to move to send this bill to a committee for inquiry. I do not support it for three reasons. First, it provides some tacit support for euthanasia and legalised killing. Second, if there is merit in any inquiry into euthanasia the authors of this bill would have initiated it last year when the bill was introduced. Third, this House has just concluded an inquiry into palliative care so a further inquiry into euthanasia is not warranted at this time.

The bill is ill-conceived. It has a perverse effect of delivering a less caring, less compassionate and less loving society. It is seriously flawed, inconsistent and ambiguous. It lacks the adequate safeguards and is an expansionary version of the previously defeated 2013 bill. It undermines the dignity that should be ascribed to each and every person and is opposed by key institutions and organisations including the AMA, disability rights groups and faith-based organisations. I note the letter from Tasmanian churches in today's papers calling for the bill to be rejected and, of course, thousands of everyday Tasmanians, including those who put their names to the petition tabled this morning in this place by my colleague, Rene Hidding. The bill should be rejected.

[5.09 p.m.]

Ms COURTNEY (Bass) - Madam Speaker, I want it to be legal for an individual to choose the end of their life circumstance when their circumstances are filled with intolerable and unrelievable suffering due to advanced and incurable irreversible medical conditions.

Most of us do not choose the circumstances, let alone the timing, of our own deaths. We will all die, whether old or young, sudden or expected, sick or with incurable disease, with forewarning or without any expectation. What we are doing today is attempting to give power and self-determination back to those who are suffering and have lost the ability of self-determination due to illness or disease. I cannot imagine being in the circumstances of suffering that have been outlined by many members here today, either personally or by the side of someone I love. They are horrific stories of physical and emotional suffering, tragic stories of conflict, turmoil and loss, moving stories of love and compassion, and deeply personal stories that have far-reaching impacts on the lives of many.

Ms Giddings said in her contribution that this is about patients, and I could not agree more. While I cannot imagine the anguish, heartbreak, distress or nightmares of watching a loved one with intolerable pain, this is not about the onlooker. This is about the individual and their right to end their life. This is about a very sick, often desperate person, who is facing a pathway to a foreseeable death, whether sooner or in the future. This is about people who often, due to illness or lack of physical capacity, have become completely reliant on others and who therefore need to look to others to have their own wishes carried out.

While we talk about protecting the vulnerable in our community, do we not have an obligation to protect those vulnerable people who are sick and suffering and want to make a lucid and tested decision to end it? Why are we not protecting these people to have their wishes enacted? Making voluntary assisted dying legal does not compel any Tasmanian to do anything they do not want. What this does is to arguably hand one of the most important decisions someone can make in their life back to the individual. How could I possibly stand here and argue that I know better than a sick, dying, suffering person, who only sees before them a painful and sometimes prolonged death? How could I possibly have the arrogance as a happy, healthy, pain-free person with infinite choices, to suggest I know best for that individual?

While the vast substance of the contributions today have quite rightly been based on personal beliefs, religion, experience and deeply-held convictions, I have a tendency to frame most of the policy or legislation that comes before me by the principles of how I see the role of government. I know that might sound quite heartless or dispassionate in a debate such as this, but it is how I see my role as a legislator. I see the role of government in this as small. I support the intent of the bill because the

primary question contained is a question for the individual; it is not a question for government. Government's role is to put in place legislation that protects our most vulnerable and ensures that the standards and protocols legislated reflect community expectations.

I refer to the AMA position statement on euthanasia and physician-assisted suicide in 2016. There are two quotes I would like to read into *Hansard*:

We also believe that euthanasia legislation is a societal issue. If new legislation does come into effect, doctors must be involved in the development of the legislation, regulations and guidelines to protect doctors acting within the law, vulnerable patients and those who do not want to participate, and the wider health system.

Further:

The AMA recognises that there are divergent views within the medical profession and the broader community in relation to euthanasia and physician-assisted suicide. The AMA acknowledges that laws in relation to euthanasia and physician-assisted suicide are ultimately a matter for society and government.

Whilst I am not going to support this bill today, I want to see the intent progressed and am supporting the amendment put forward by my colleague, the member for Braddon, Mr Jaensch, not because I want it deferred but because I want to see it become law. I want the outcome of today to be a clear indication to the community that we respect the right of individual Tasmanians to make informed decisions about their own lives. I do not want this kicked into the never-never, as has been described, but what I want is a law that protects the vulnerable and incorporates some of the very relevant recommendations and implications of the recently tabled inquiry into palliative care. In my opinion it was a thorough and well-considered report and the integration of all end-of-life care must be considered. The question of voluntary assisted dying cannot be answered in isolation.

Let me repeat, Mr Deputy Speaker, my motivation is not to kick it down the road indefinitely. We need to find a pathway that gives incredibly unwell people the right to self determination. I agree that we cannot keep deferring it because it is tricky, messy and full of challenges, but the implications of voting for a bill of this nature are serious and far-reaching and I take them very seriously. There are still many contributions that are going to be made this afternoon and this evening and I very much hope that a committee is formed with a clear intent of navigating a pathway where we can see this option available to Tasmanians.

I thank the Premier for offering those on this side of the House a conscience vote and I also extend my thanks to all the constituents who have taken their time to make their feelings and representations known to me. While I have not had the opportunity to respond to many, I thank them. Many people have shared deeply moving and personal accounts and I respect all their views. Even if my vote today does not happen to reflect their views I would like to assure Tasmanians that I have taken them into account and am very much doing what I feel is the right thing for our community.

[5.16 p.m.]

Ms WOODRUFF (Franklin) - Mr Deputy Speaker, I rise on behalf of all the people who are suffering enduring and unbearable pain at the end of their lives from a disease or condition that will only get worse and never better, from which there is no escape but death, and who are living with the

daily indignities of a body disintegrating far before their last breath is drawn. On behalf of these people, and those who love them and will be forced to observe their pain and suffering, I rise with good conscience to strongly support this bill.

The intention of this bill is to provide a safe and compassionate end-of-life option for people so they can choose, if they wish, to live their last days without intolerable suffering from a disease or condition that has no cure.

This bill is about the right of individuals in this situation to choose their own moment of death, free from the ideology or views of others and from the interference of governments in this most private and personal of all decisions. The legislation to provide voluntary assisted dying has been in place in some jurisdictions for up to 30 years now. It is now available in five European countries, across the whole of Canada, in at least six states in the United States of America, and in Colombia. These places have legalised assisted dying and have robust frameworks that have been much discussed by the legal, medical and ethical communities in those countries.

As we sit here in this Chamber tonight, other countries and jurisdictions around the world are writing legislation and debating it in parliaments. The Victorian Parliament's Legal and Social Issues Committee conducted the most extensive inquiry into end-of-life choices in Australia. They travelled overseas to hold public hearings with doctors, nurses, palliative care specialists, disability rights groups, academics, supporters and opponents of these legal frameworks. Their report, which they tabled in June last year, is extremely comprehensive.

The bill before us today builds on their findings. It allows competent adults in intolerable suffering the option to choose the moment of the end of their life. I believe the contemporary and extensive international evidence collected through the Victorian inquiry which informs this bill should provide solace to all the concerns that people have voiced in their submissions against the bill to me, with the exception of those around faith-based ideology.

The Victorian inquiry found no evidence that any corrosion of institutions has occurred in other countries which have introduced similar legislation. They found no evidence of a slide towards involuntary euthanasia by the state. They found no evidence of a rise in vulnerable, elderly people choosing death for the convenience of their families or to prevent them being a burden to society.

Opponents of voluntary assisted dying typically clothe their ideological opposition to a person taking one's own life by making assertions, as we have heard this evening, about much evidence and many stories of the negative impacts on elderly and disabled people as a result of voluntary assisted dying legislation in other countries. They never provide actual credible data to back these up. The number of people in Oregon and Switzerland who die using assisted dying has been stable at 0.4 per cent of all deaths. The Victorian parliamentary inquiry set out to investigate these assertions and found no basis to support them. They returned to Victoria and concluded the government should legislate for Victorians to have the option of assisted dying.

The conditions prescribed in this bill are extensive and detailed. They are designed specifically to prevent the possibility of any undue influence being placed on a person who wishes to have medical assistance to end their own life.

I will say something about the role of doctors as that has been much discussed in the media and in the Chamber tonight and particularly the Australian Medical Association. The AMA has made much of its survey of physicians' views. They failed to mention only 12 per cent of members responded to their survey, which is staggeringly and disgracefully low. Even worse, the results from that survey have been misreported. More than half of the respondents, 52 per cent, believe euthanasia can form a

legitimate part of medical care, which was survey question 11 and 45 per cent of them believe the same for physician-assisted suicide, survey question 20.

Some people are concerned the legal right to voluntary assisted dying could put a physician in a situation where they could feel a conflict in the doctor-patient relationship. It is often misrepresented that the primary role of a doctor is to do no harm and to protect life. It is the case that the Hippocratic Oath is about caring for patients and empowering them.

On the matter of GP involvement, I return continually to the fact that physicians who do not want to be involved in assisting a patient to die, will never have to under this legislation. If your views are offended by the idea of assisting a patient in unbearable pain to seek peace by assisting them to die, rest assured this legislation makes it clear you would never be compelled to act against your own morals. How is it just or compassionate for someone to use their own personal beliefs to deny a dying person the right to have someone else assist them with their choice? This denial sentences a person to endure the rest of their natural life in suffering and indignity.

I will read some of the words spoken by Gideon Cordova. I am not sure if he is still here tonight, but he and his mother Nikki were here until recently. Gideon is the son of Robert, who died of motor neuron disease some years ago. Gideon spoke at lunch time today to hundreds of people who came to the rally outside this House demanding we adopt this legislation. One of the many points he made was that a person has a number of legal options in front of them which were: suffocation, sedation, starvation or suicide. These are all intolerable options, the things you would never want to choose for a person you love or for yourself as the way to end a life.

We are in this situation because we put up the straw horse assertions made tonight as reasons for arguing against the bill. These are false reasons and they have been proven to be false. The arguments within the AMA I find the most interesting and concerning are around the grey area physicians operate in and the difficulty they have carrying out their work and having to make choices that are on behalf of another person and their life. These people are asking for legal cover to allow them to have an open conversation with a patient and their family and to give them the dignity they would so dearly love. Some of the physicians who work in regional areas are regularly placed in lonely and emotionally draining situations, as they do their best to ease their patients' passage into death. They have no collegial or legal support and are often left on their own to make the hardest of choices about how to manage patients who are pleading with them to end their life.

[Dr Alida Lancee](#) wrote an article in the Go Gentle book *The Damage Done*. I thank the people who put that publication together at very short notice last year. It is an incredible and inspiring book and I recommend it to anybody who has not yet had the chance to read the stories in there. Dr Alida Lancee wrote that the choices she was required to make as a regional GP were similar to the isolation and scheming that occurred in the past in backyard abortions which, like assisted dying, are carried out in all countries whether it is legal or not. The advantage of a legal framework is that it provides a strong ethical framework as well and safe and supportive care for the patient.

Voluntary assisted dying is not an alternative option to continuing to work to improve palliative care and treatments. It is not one or the other. That is a false argument. Both are essential tools we must have available for people to choose from in their own end of life decision-making process. Palliation does not work for all conditions and diseases. In the AMA's survey of their members, question 3 asks, 'To what extent do you agree with the following statement: that there are patients for whom palliative care or other end of life care services cannot adequately alleviate their suffering?' The physicians' response to that was 32 per cent strongly agreed and 36 per cent agreed, a combined response of 68 per cent of physicians who agreed that medication cannot remove all forms of mental and physical suffering in patients.

Every person is different; every disease course is different as well. Some cancers, in particular bone and liver, are especially hard to palliate. Some people have less tolerance than others for medications. Others have adverse drug reactions. Some have complex interactions, or people have neurological conditions that simply cannot be treated at all. One nurse wrote to me about her experiences of nursing dying people in northern Tasmania. She particularly remembers a woman with intractable pain who persisted for several weeks as her skin fell from her body in sheets, exposing raw nerve endings. All avenues of pain management had been trialled, with no success. She remembers sitting with the woman who begged her to please help me to end this; this pain, this life is unbearable. All that nurse was able to offer was her shoulder and her own tears which were patently not enough. That woman suffered another nine days in terrible agony, finally succumbing to medical sedation.

It is especially frightening for people with progressive multiple sclerosis or motor neurone disease who live for years enduring the unendurable, and Gideon Cordover spoke with strength and clarity about his father, Robert, and his existential suffering. The inability of Robert to enjoy the little things of life that make life worth living, such as speech and movement, no amount of palliation can relieve that suffering. This was ultimately the cause, Gideon said, of his father taking his own life earlier than he otherwise would have. He was forced to commit suicide before he lost the physical capacity to commit that act himself because there was not a law in place to have someone assist him at a later time.

Laurie Daniels wrote about, slowly over seven years, losing her job, her driver's licence, her identity and autonomy due to multiple sclerosis, about being locked sitting upright into a wheelchair all day, every day, housebound with nothing to do, unable to dress, bathe or feed herself. She has a lively mind and is shortly expecting to even be unable to communicate her wishes to her carer. It is a fiction that institutions can ease suffering and despair like this and provide a meaningful existence right to the end of a person's life.

The views of doctors should not be given precedence in this debate. It is time for them to stand aside and give patients the choice about the timing of their own death. Doctors already make decisions to involuntarily end patients' lives such as by not giving antibiotics to a 90-year-old woman with a severe lung infection, or by increasing the dose of morphine from 10 to 20 milligrams for a man suffering with incurable brain cancer. It is time to put this decision in patients' hands, not in doctors' hands.

Tasmanians overwhelmingly want legislation to allow a more compassionate way of approaching death. We are increasingly ageing with passion and leaping into later life with vigour. We will no longer submit to being parked in institutions or facilities to suffer silently and unnoticed. We demand a say in every precious moment of our short lives, including a say about our illness management. As we approach death we expect to have choices about how we live until our last breath. We want that control. We increasingly want to die at home with the best palliation possible.

More and more of us want to participate in our funeral arrangements which is also part of the passage towards death. As Laurie Daniels says we must not turn away from change in the law. We should be allowed to use a medically prescribed substance to swiftly end our life if we are in prolonged and excruciating pain in the company of people who care about us. The informed and lucid choice should rest with the person who is living the process of dying with the support of another kind person who voluntarily agrees to help them.

I firmly believe that through providing people with the dignity and respect that this bill enshrines we are honouring the sanctity of every breath in a person's life. I had tears in my eyes when I listened to the speech by the member for Braddon, Mr Jaensch. I found his reasons for not supporting the bill to be incredibly shallow and empty talking about drafting errors. I thought it was gutless and shameful to suggest that at this stage it be referred to a committee to prolong a debate about a subject that has

been conclusively decided by the vast majority of Tasmanians. The flimsy arguments presented show beyond a shadow of a doubt that people with a mind like that are unutterably close to shifting their views.

It is a complete waste of our time and our taxpayers' money to take this to another committee. Instead, we should listen to the hundreds of people who were standing outside parliament today, all the voices that they represent. On behalf of them, I am proud to vote in favour of this life-affirming bill, and I will do whatever I can to bring this to a legislative conclusion.

[5.35 p.m.]

Dr BROAD (Braddon) - Mr Deputy Speaker, I stand here today, conflicted. It is something that I feel wholly unprepared to discuss, but I have to; that is my job. In my experiences previously in council and so on, what I always liked to do was explain to people why I am making a decision, and that is what I am doing today. I do not come to this debate with a religious perspective, nor am I thinking in political terms of gains or losses.

Like others, I too have seen loved ones die in circumstances that were less than the ideal of a dignified and peaceful death. This is a very difficult debate for me because both sides make very valid points. However, this is not a new debate. I was surprised to find that similar debates have been had in multiple countries since the 1880s and indeed even earlier, and that the general principles for and against basically have not changed over time except for the names used to describe the process.

I have been unsure as to what to do, so I have spoken with those close to me and have looked at what others have written. I have also read all the correspondence I have received on the topic and thank everybody who has taken the time to express their ideas both for and against. I honestly thank them for their input. It has been very valuable.

I have also looked at the literature on this issue, and I found an article particularly helpful from last year. That was in the *Journal of Critical Care Medicine*. It was titled 'Physician-assisted suicide and euthanasia in the ICU: a dialogue on core ethical issues'. This article gives what I think is an even treatment of both sides of the argument from the perspective of doctors, for and against. While this is coming from the perspective of a doctor and is somewhat lacking in emotion, I think it does reflect both sides of the debate that we see in the public arena. The article discusses four distinct areas: one, the benefit or harm of death itself; two, the relationship between physician-assisted suicide and euthanasia and withholding or withdrawing life support; three, the morality of a physician deliberately causing death; and finally, the management of conscientious objection related to the physician-assisted suicide and euthanasia in a critical care setting.

There was consensus on the right of doctors to have a conscientious objection when it comes to performing assisted suicide, and I will not discuss this, but there are three remaining areas which form the basis of my discussion that follows. One is the benefit or harm of death itself. Are there patients who would benefit from death? The pro side accepts the positive aspects of being alive are sometimes outweighed by the burden of being alive and the suffering, and by the value of honouring a patient's considered wish for death. The anti-side agrees that life need not be prolonged at all costs; however, they found it hard to argue confidently that death itself is a benefit. Death is beneficial to patients if, and only if, they are better off dead. However, in determining whether patients are better off dead, this argument gets very philosophical because doctors and patients have no idea what it is like to be dead. It is a bit of a stupid argument. The anti side then argues that although the dying process would certainly have unwanted negatives in terms of pain and suffering - for which they advocate aggressive and much-improved approaches to palliative care - the dying process itself can also be a time for

existential and spiritual healing through growth in personal and relational wholeness, as well as individual learning from patients, their loved ones and those caring for them.

There are those who die undignified and painful deaths. My own much-loved grandmother died after a long battle with Parkinson's. Unbeknownst to me, she spoke to my father about killing herself. 'If I had a gun, I would shoot myself,' she said. This was soon after her diagnosis. She knew she was not going to get better and that death would not be quick, and in fact, it took years. This is a common theme in that fear of what is coming can motivate patients to seek assisted suicide. In fact, in reviews of assisted suicide legislation around the world, pain does not tend to be the main motivating factor in seeking assisted suicide. Instead, patients commonly cited loss of autonomy and dignity, no longer enjoying life and depression as their reasons for wanting to die. However, suffering is not just about physical pain, it is also about psychological, emotional, existential and other social factors.

Pain itself is a complex thing. It is not simply a certain amount of injury causing a certain severity or volume of pain for everybody. Everybody experiences pain differently, depending on their emotional state, cultural beliefs, depressive illnesses, whether they remain active and so on. This is basically because other factors also modulate pain in the brain. The other night I saw an experiment on TV where people were given short, sharp electric shocks and their physical reaction was monitored. Where patients were given random shocks, they had greater reactions than when they knew exactly when the pain would come due to a countdown. While this is obviously not the same as pain associated with terminal illness, it highlighted to me that engaging the brain can assist in the tolerance and management of pain itself. Suffering of not only patients but their families and the professional caregivers attending them is highly and inextricably inter-related. The perceived distress of others of any of these groups amplifies the distress on others as well.

Suffering is also caused by other physical symptoms in terminal patients, and we have heard a lot about those today. We have heard about fatigue, generalised weakness, laboured breathing, delirium, loss of bowel and bladder function, nausea and vomiting, to name just a few. In my own personal experience, the last time I saw my grandmother was only two days before she died and she was basically a skeleton. She was very frail and had been bedridden for some time. This had progressively happened over a long period. She had been unable to eat for some time, had been unable to gain weight and did not have a good quality of life. I knew when I last saw her that she would not have long to live. In the end she died from an infection which likely came from bed sores, as she was unable to move and was in a severely weakened state. However, I never heard her complain and she remained stoic to the end. I was surprised to hear that she had spoken to my father about suicide and I only heard about this when I was discussing this bill with my family in recent weeks.

Suicidal thoughts are not uncommon in terminal patients. It is also common for patients wishing to die in early diagnosis, only to find meaning and accept their fate. I have read in the literature that with disease progression patient attitudes can change, with suicide a less likely option. I am not sure what my grandmother was thinking or how her mind changed. I did not see her angst, but of course I wish she was still around to ask.

The other personal experience I have is with another close family member who died of pancreatic cancer. She expressed a wish to die on a couple of occasions when I saw her in hospital but I never got the impression she was serious. In discussions with other family members this was more about uncontrolled pain. When the pain was treated she was not suicidal.

This brings me to the next area of discussion, which is the relationship between assisted suicide or withholding or withdrawing life support. There is a clear distinction for me and it is about intent. Does the doctor intend to kill or relieve suffering? The issue of double effect, which has been discussed here in this place already, needs to be clarified in law. Withdrawing treatment is not the

same as assisting suicide. I have seen this in action and have heard stories from others. This goes to end-of-life choices.

The first example came from Gavin Austin, the former CEO of the North West Regional Hospital, and he talked of his father who was severely disabled. He looked at his father and said 'Dad, you've got a melanoma on your head. We need to get that treated.' He said, 'I know', but he did not receive treatment and in the end that melanoma killed him. That was his choice. A close friend of my father was suffering from a mesothelioma-related illness and was a long way into his treatment when he got to the point where he just said, 'I've had enough', and withdrew treatment. His family were devastated by this and fought and sought to change his mind but he did not and it was only weeks after he withdrew treatment that he died, but that was the way he wanted to go and withdrawing treatment and turning to palliation was his option.

Another experience was with my wife's grandfather who had seen his wife die. He was in his eighties and he had a 'do not resuscitate' order. He was dying of congenital heart failure and I remember him slowly being palliated in a nursing home surrounded by his family who were doing rotations. That was his wish; that was the way he wanted to go. I remember my wife saying, 'But why won't he have treatment? Why won't he fight that last inch?', but he wanted to go that way and he died the way he wanted, and I believe withdrawing treatment is a distinct option.

The final question relates to the morality of a physician deliberately causing death. We have talked about that. The Greek physician Hippocrates argued that physicians should not give a deadly drug to any patient. The Hippocratic duty of doctors requires them to do the best for their patients and not deliberately kill or harm them. When patients cannot be cured or treated effectively, treatment goals should shift to palliation. Medical practitioners have expressed concern about the responsibility placed on their profession to assess whether their request is an eligible request.

The course and nature of any advancing incurable, irreversible medical condition is often unpredictable. A prognosis may be wrong. A disease may go into remission. A treatment may be effective. We have all seen numerous examples of previously incurable diseases being cured by new experimental treatments such as immunotherapy and there are some good examples in melanoma research where there has been a complete turnaround. This places an unrealistic burden on the responsibility of medical practitioners and for me this is a key question, although experience from overseas proves that there are doctors willing to assist patients to end their lives.

The key question I have been tossing around in my own mind and from my own experience is whether it is better to alleviate persistent suffering through palliation or through assisted suicide? In a review in the *Lancet* in 2016 there was a statement that there is a growing body of evidence that early involvement in palliative care is associated with improved quality of life, symptom burden, patient and caregiver satisfaction, and that outpatient palliative care is associated with significant improvement in end-of-life outcomes. It is all about the timely introduction of palliative care and also to facilitate end-of-life discussions. When referrals come too late it can lead to uncontrolled symptoms, emotional crises and unwanted and aggressive end-of-life medical treatments.

The research shows that pain pathways are complicated but we are understanding more and more, and I have had two distinct discussions with doctors and anaesthetists about pain relief and palliation. The first is about short-term palliation and the second is about long-term palliation. The doctors I have spoken to discuss palliation options that include opiates, spinal blocks, sedation and, indeed, terminal sedation. In my mind it is fairly clear that when you have hours and days to go that the palliative options are quite well established. I have been made aware that there are also multiple non-opiate options which may be used in long-lasting pain and these are the sorts of things that can be put into play by a good palliative care team.

Contemporary palliation involves a team and should be started early. In situations where patients and their families have not had good information about their condition and prognosis and treatment options, they feel scared, uncertain and do not feel in control of their future. Obviously when pain starts affecting a patient and their ability to function they do things like they give up work, they give up sport, their relationships suffer, and it can become a vicious cycle. The individual now only has their pain and fear of future and is left to think about their comparatively short, painful future.

One thing I was not aware of is that there are actual changes in the pain pathways in the central nervous system in terms of the neurochemistry in these people to heighten their pain experience, especially when they start late. The member for Braddon, Mr Jaensch, discussed this briefly. If it is left too late and the pain is too intense, when you start giving pain medication you have to give higher and higher doses because of these altered pathways. It is not a good practice so it is better to start with pain medication early in the treatment. We need a better transition from curative to palliative treatment so that once the patient becomes terminal and the prognosis is that it cannot be cured there should be a smoother transition to the palliative pathway.

Obviously this is not always easy but we understand pain so much better now and so many options are in our armoury to improve the experience of patients with cancer and pain.

It was highlighted that a request for assisted death is a sign of an unresolved problem that needs to be sorted out. This was my personal experience. When my close family member was requesting assistance in suicide, that was more about her pain relief. Once her pain was relieved that suicidal ideation went away. This could be because they are not taking their medication and they are scared, their treatment is inadequate, or those around them are having an influence on their mood. It may be they do not feel supported. There are many things that can impact people when it comes to pain. It is about physical pain and all the emotions around it.

I have seen people die. I have been involved. I have seen people withdraw treatment. I am not comfortable with the bill in its current form. There may be those who still suffer -

Ms O'Connor - There are those who still suffer, with respect.

Dr BROAD - Let me make my point. There are those who will suffer and some of the stories here are harrowing. I add that some of the stories that were discussed here today, particularly with people committing suicide before dementia took them, are not covered by this bill.

My concern is about the treatment of the pain side of suffering rather than the emotional/mental side of suffering. I have come to the position after much thought that this is where we should be putting in our efforts. We should be putting our efforts into assisting the relief of pain, the research into higher level palliative options and coming up with better solutions to the management of pain rather than assisting suicide.

There is also the association of depression in considering assisted suicide. Suicide ideation was more closely correlated with mood disturbance and degree of depression than with pain. It has been argued people with insufferable pain are already ending their lives and this is true. However, even in countries where assisted suicide is available, people seek advice on how to commit suicide unassisted and still take their own lives because they do not want potential intervention. Some with suicidal thoughts do not discuss this with their doctors because they do not want to be talked out of it.

The other issue for me is that there are far too many who commit suicide without having any medical issue. When researching assisted suicide in other jurisdictions researchers have suggested that depression and psychological distress tend to be significant drivers for euthanasia and assisted suicide,

yet we are not involving psychiatrists, psychologists and social workers in these decisions. We ought to look closely at the safeguards we have placed around mental health issues.

I have come to the position that our focus should be on symptom relief rather than death. I have some specific issues with the bill. First, there is no time frame on diagnosis. All the US states require patients to have a prognosis of a survival of six months or less; they are terminal. The bill before us does not give a time line along those matters. The definitions mean this option will not be limited to those with terminal illness. This is a big problem for me. To go anywhere near this it has to be about terminal illness.

I am not influenced by the slippery slope arguments. In the United States the concern that minorities, disabled and the poor and other socio-economically marginalise groups might be pressured to accept assisted suicide does not seem to be borne out. In Oregon, patients choosing assisted dying are overwhelmingly white and, on average, more financially secure and more highly educated.

It has been argued in the literature that if assisted suicide is justified for some patients then it is discriminatory not to provide equivalent access to death for patients with paralysis, dementia and other neuropsychological conditions. These arguments have been used to extend the range of eligible persons in other countries. That side of the slippery slope argument is borne out by experiences in other countries.

I have experienced angst over this. When I knew this was coming up, I did not know which way to go. I hope people accept this is a difficult decision. I have come to the conclusion that the dominant motivations for people requesting assisted suicide includes loss of autonomy and dignity, inability to enjoy life and regular activities, and other forms of mental distress. Existing data shows that the pain is a minor motivation. This is the major concern for me and, unfortunately, I cannot support the bill.

Time expired.

[5.55 p.m.]

Mr HIDDING (Lyons - Minister for Police, Fire and Emergency Management) - Mr Deputy Speaker, the debate has generally been of good tenor. The contribution just made was deeply thoughtful. The chief political attack a few minutes ago by the member for Franklin, Ms Woodruff, does her no credit whatsoever.

Ms O'Connor - She was just telling the truth.

Mr HIDDING - I am unhappy that the two proponents of this bill would choose National Palliative Care Week to bring this bill on. This is a pro-suicide bill, it is antithetical to palliative care and I am deeply uncomfortable about that.

Ms O'Connor - It was the week that was offered to us by the Leader of Government Business, Mr Ferguson.

Mr HIDDING - To address the question of a committee before the House, I would prefer this bill not be taken to a committee. The bill is fundamentally flawed and should not be given credence, or any maybe, that it might be possible to pass this at some stage. It does not seek to address people with terminal illness. It is a much lower bar than that, which has occurred with this bill. It is for that reason I will not be supporting the inquiry.

This is the fourth time in my career I have been engaged with the proposition that Tasmania should relax its murder laws to allow for the early taking of life by the medical profession. This public policy proposition has been called all sorts of things - physician-assisted suicide, voluntary euthanasia, dying with dignity - but they are all simply names. The proposition is that this parliament provides for the early termination of human life, earlier than it would otherwise occur, by state-sanctioned medical doctors.

The challenge for every member of this House today is whether we can safely vote for something such as this. While it might initially benefit a few, if it was to place a much larger number of our constituents at risk of being coerced into 'doing the right thing' then we have an appalling situation of moral suasion which will be given birth should this bill become law.

This is not a bill to provide for release from the fight for life for someone with a terminal illness. Someone with diabetes, dementia or chronic arthritis can access state-provided suicide under the terms of this bill.

There are horrible deaths and there is horrible suffering. I am not going to add to those discussions, neither am I going to speak about my mother. I was stirred by the last contribution about a grandmother. We, as migrants, did not have grandparents. We did, but we never knew them. I have spoken before about my mother and that drives a lot of my thinking about this.

We previously agreed that no one in this House has a mortgage on compassion. However, today our moral relativities are being put to the test. I believe we are walking into a minefield with this legislation and into a genuine public policy danger zone. This public policy danger zone is a consideration of the needs of the less educated, the less erudite, the less competent members of the community who would without question have their lives changed if this bill is passed by this House today.

Many elderly, frail and sick Tasmanians are deeply trusting and have deeply connected relationships with their carers, their doctors, their nurses and their families. There is absolute trust, but this will change if this bill became law. As if their physical challenges were not bad enough, they would have to engage in deep worrying about whether anyone around them has any other thought in mind other than the 100 per cent love and care for the wellbeing they enjoy now.

In 1998 this House, then still at 35 members, instigated a major House of Assembly inquiry into the need for legislation for voluntary euthanasia. It was the most comprehensive inquiry, likely one of the biggest unicameral inquiries of this parliament. The inquiry was chaired by that sometimes ferocious social reformer, Judy Jackson, from the state opposition. The terms of reference were:

To inquire into and report on the need for legislation in Tasmania to allow for voluntary euthanasia or assisted suicide for the terminally ill, having regard to -

- (a) social;
- (b) ethical; and
- (c) legal implications of such legislation.

I was appointed to this committee along with the then minister Denise Swan, Paula Wriedt and Di Hollister of the Greens. It is fair to say the vast majority of this group expected to nail this and recommend for Tasmania to lead the nation, if not the world, with such legislation. We travelled the

nation, took evidence from some 1100 people locally and nationally, including many public hearings. To the obvious surprise of many on the committee, given their strongly held views prior to beginning this inquiry, the committee was eventually unanimously obliged to find that the evidence was clear and definite that legislation such as this was downright dangerous for the vulnerable and frail in the community. The committee found - and I will read finding 2 from the report:

The polarised nature of this debate for and against voluntary euthanasia limited its utility as a determinant for legal reform. Euthanasia legislation would have to be based on a general principle that treated all citizens equally.

There is the problem. In this place we have to treat all citizens equally.

The committee also found the legislation for voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation of the state to protect all its citizens equally outweighs the individual's freedom to choose voluntary euthanasia. When I speak about this people say, 'That's 20 years ago. Life's moved on. What's that got to do with me?'

Let us look at whether life has moved on that far in 19 years. First, do we have more or fewer vulnerable members in our society these days? I would say we have more. We have a strongly ageing community in Tasmania, with a much higher percentage of people over the age of 55 than was the case 19 years ago. Let us look at doctors. The AMA is still opposed. They were opposed in 1998 and 19 years later they are still opposed. The disability sector is still opposed. Life Worth Living, an organisation of disability advocates, has declared this bill to be even more obtuse and worrying than the last one of a few years ago. The Law Society stands behind its previous deep concerns of the last bill. The aged care sector is still opposed. Southern Cross Care is not the only operator in the state but has the most and biggest facilities in the state, and the chairman is a former premier of Tasmania, the honourable Ray Groom. He wrote recently that Southern Cross has a high trust model of care and aged care patients put their entire existence into the hands of caring and loving employees at Southern Cross Care. The whole model of aged care is rocked to its very foundations by this issue being a possibility.

There is a new understanding in the past 19 years and that is the issue of elder abuse. There was a very good contribution today in an op-ed in the *Examiner* by Dr Jeremy Prichard that says having legislation such as this is deeply worrying in terms of elder abuse. In Britain recently there were 330 votes to 18 on the back of a simple truth-based campaign by the British disability sector. Regarding pain relief and control development, are we worse off 19 years later or better off? In pain relief and control we are hugely better off, far more advanced. That would tend to make the case that there is even less need for a pro-suicide bill such as this as there was 19 years ago.

As for the slippery slope, I will simply say that Professor Theodor de Boer of Utrecht University was one of the original proponents for euthanasia in the Netherlands. He saw it as being available to a small number of people in terminal cases. Now they are at 6000 a year and rising every year. He is deeply worried and, in fact, is the Achilles heel to the whole euthanasia debate worldwide. He is a senior biomedical law lecturer and he has thrown a bomb into this debate. He became horrified that from his original idea that a handful of intractable cases would qualify for an early death, he has watched in horror as government-arranged deaths in the Netherlands have increased by a massive 15 per cent every year as the death toll of this legislation is a record 6000 per year and climbing.

He has expressed real fears that his country will slip further down the slope into increased numbers coming from the dementia and depression existential medical conditions sector. He said recently, and I am sure he was serious about it, that he believes activists will not rest until the government in the

Netherlands issues a legal pill to every citizen on their seventieth birthday. He admits in shame that he was wrong and terribly wrong.

Mr Deputy Speaker, I will seek to deal with a couple of key subjects that are consistently put to support the notion of voluntary assisted dying or whatever we choose to call it today. There is the notion of autonomy - 'It is my body, I can do with it what I want.' Of course you can, but you are asking in this case for a state-sponsored doctor to do it to you. In fact, you would be gone but the doctor lives on, so you need to think that through. That is not autonomy; that is more people than just you. That is not an autonomy situation.

Full autonomy over your own body is a very fine value to hold but life is not that simple unless you are a complete narcissist. Full, unfettered autonomy is great if it affects no-one else. But if access to full autonomy for yourself removes that autonomy from all the weak and vulnerable people around you, it is a pretty poor value to hold. Someone wrote this week that to make a value such as full autonomy over one's body absolute would lead to anarchy and chaos. Absolute freedom for autonomy for all would lead to nothing but misery and pain for most.

People who talk about euthanasia legislation sweeping the world and how it is going to be everywhere in a few years' time are creating a new religion. In a different article that was quoted recently, Paul Kelly spoke about this new wave of morality he has called 'the secular fundamentalists', and he is dead right. Moral issues such as parking your own needs in case they endanger a fellow citizen is so old-fashioned. How could anybody possibly think like that? Secular fundamentalists are desperate to drive conviction and faith-based MPs like me out of the public square. It is continual oppression. Leave your bible at the door, leave your beliefs at the door and come in here without that. What happens then is that the secular fundamentalists come in here with a religious passion that would put a holy-roller tent operator to shame. Apply that to somebody humbly trying to put a Christian point of view.

I will never lose a picture in my mind of a protester in the United States some time ago - I was told about this by the pastor in our church - with a sign on the front saying, 'No death penalty' and on the back of his sign, 'Free abortion rights for all'. There it was, captured in one protestor. On the front of the sign, no penalty for somebody criminally convicted of murder, and on the back of the sign, death penalty for somebody at the most innocent part of their life. There is not a lot of thinking that goes into a lot of this, and I am deeply concerned that the world is leading towards this sort of instant autonomy - 'I will do what I want and we will not be too concerned about other people'.

Questions are deeply challenged and disturbed by the shedding of the old-fashioned care for your neighbour. Jesus Christ paraphrased the Ten Commandments like this. The Ten Commandments came down to first, love your God, and second, love your neighbour. The challenge is if a Christian loves his neighbour it may be necessary to deny yourself things that put that neighbour at a disadvantage to you. That is the challenge. That is at the heart of this debate today. I am not preaching from the Bible. This lives at the base of 400 years of Westminster parliamentary structure and law unashamedly based on the Ten Commandments of the Judeo-Christian faith.

Ms O'Connor - The Bible also says that parents can stone their children who argue with them to death.

Mr DEPUTY SPEAKER - Order.

Mr HIDDING - That has been raised by you before in this place and of course that is the Old Testament. What you keep saying about the stoning and the rest of it, is wrong. I am not getting into a theology argument with you at this stage of the night.

I will now address the issue that you often hear, particularly from farmers who talk about what you would do with your dog or your horse. You would not let them be in pain, you would take them out the back and take care of them. The fact is we are sentient beings. Human beings were created as the most complex entities in creation. Hundreds of billions of dollars are spent every year around the world to unravel the wonders of God's creation of humans. All universities of the world are less than a quarter of the way to understanding this creation. You might shoot dogs and horses, but you cannot treat sentient beings with a conscience as though they are dumb animals. That should not ever come into this debate. I have not heard it here this day, I must say, but it is often raised with me and you read it in the paper - if it is a humane thing to do to an animal why would you not do it to a human?

The other matter I will raise is the issue of this being something many people want. John Howard said to me many years ago, 'Rene, don't follow the mob. They will eventually turn on you for doing so. Have principles and apply them and do not run with every -

Ms O'Connor - Eighty-five per cent.

Mr HIDDING - The next honest survey of people on this subject I see will be the first one. You ask anybody a simple question like that and of course you are going to get 85 per cent.

The fact is at the end of the inquiry in 1998 Di Hollister, the Green member, asked a question of a leading [bioethicist](#), 'What would you have me say to my educated, informed, connected friends who want the right to choose euthanasia for themselves?' The answer was and it is on the *Hansard* of that hearing:

Madam, I would ask your friends to have a care for the less educated, the less informed, the less connected people around your friends who would be put at risk because of this.

At this point I want to reach out to all Tasmanians who are going through, or preparing to go through, or worrying about going through the inevitable stages of an end of life continuum. To all those Tasmanians, I wish and pray for them that they will find the peace and the quiet strength to deal with their challenges, that they experience world class medical, palliative and aged care in all our wonderful facilities around Tasmania, and that they be surrounded with the deep love of their family and loved ones every step of the way. When their time comes that it is a peaceful and gentle passing from this life. I know that is not always the case and often it is a traumatic thing. I do sincerely pray for all Tasmanians.

Madam Speaker, I cannot support this bill being further considered elsewhere because I believe it is fundamentally flawed. I will be voting against this bill.

[6.14 p.m.]

Mr BACON (Denison) - Madam Speaker, it gives me pleasure to speak. I place on the record my thanks to the Leader of the Greens, Cassy O'Connor and Lara Giddings, the member for Franklin and former leader of the Labor Party, for bringing this bill on. I have enjoyed the contributions of different members of the House, some that have been for and some that have been against. When we come into this House on issues of conscience we can speak from our own personal background, our own personal beliefs and we can all respect each other, whether or not we agree. I respect those who are for this bill and those who have spoken against this bill.

I would like to see the bill passed, but if that is not possible, then at least it goes into the Committee stages so that people who support the intent of the bill but have a problem with the specifics can work

through those issues and have the bill fully debated. I will also read into the *Hansard* some comments that Lara Giddings, the member for Franklin was going to make but was cut short because of the time. She has asked me to read some of that into the *Hansard*. Consider these further words from the member for Franklin:

This legislation will only allow an assisted death for eligible people who make persistent, consistent and voluntary requests. There are multiple checks to establish and confirm that each request has been made voluntarily and on an informed basis. The primary medical practitioner will be required to talk to the person about the reasons for their request. If he or she is concerned that the person is not making a voluntary request they will be able to refer the person for counselling at any time during the process in order to remove any doubt.

The written request is also an important safeguard to establish and confirm that the person is making a voluntary request. Under this bill the person making the request must be mentally competent to do so and to understand the implications of their request. They cannot be suffering from a mental health condition to a degree that may cause the judgment of the person to be impaired.

One of the important safeguards in this process is the assurance that the person making the request is doing so with all the relevant information in front of them, including information on their medical condition, their prognosis, treatment options and the process to go through for an assisted death, including the risks associated. While the bill specifies that a person must be informed about palliative care options as part of making an informed decision, we are not mandating that a person undergo palliative treatment before they can request an assisted death. After all, in the Tasmanian health system you cannot be forced to go through any treatment.

This legislation allows for the person and their primary medical practitioner to decide if a doctor will administer the medication to the person, or if the person is to self administer the medication. In cases of self-administered assisted dying, the person's primary medical practitioner must remain on the same premises as the person while the person self administers the prescribed medication, in case it goes wrong. In Oregon there have been a small number of reported cases where the person has regurgitated the medication or regained consciousness after taking the medication. There is no ability under the Oregon act for the attending doctor to provide any further assistance to the person.

The step-by-step process for a person who meets the eligibility criteria and wants to access an assisted death is as follows: a person must make three requests for assistance, an initial oral request, and no sooner than 48 hours later a written request, and no sooner than seven days later another oral request. It is important to note the subsequent oral request cannot be made until the primary medical practitioner has received a written report from a secondary medical practitioner that confirms the person's medical diagnosis and prognosis. The delays enable time for a person to change their mind, but is also cognisant that people applying for this process are in the advanced stages of their illness and are suffering intolerable pain. They do not want unnecessary delays once they have come to the conclusion that they cannot go on with living. A person can rescind their request at any time and in any manner.

A strong safeguard in the system is the requirement that two doctors confirm that the person has an eligible condition. If the secondary medical practitioner's written report does not confirm the diagnosis or prognosis of the person, then a referral to another secondary medical practitioner may be made. However, if this doctor also does not confirm the medical diagnosis or prognosis for the person, all existing assisted-dying requests of the person are rescinded and the process ends at that point. Once all criteria have been met and the process completed, the primary medical practitioner can prescribe the medication. He or she must keep possession of the medication once dispensed by

the pharmacist until it is administered or returned if a request for assistance to die is rescinded. The primary practitioner must offer the person an opportunity to rescind their request at a number of points during the process, including immediately prior to the person taking the medication. A review process, using the Registrar, will also be implemented through this bill to monitor compliance with the law.

This bill provides a legal framework that allows for voluntary assisted dying. It will increase transparency of decision-making around these issues and will require proper legal processes particularly around decision-making and reporting.

There will need to be some amendment made to the bill to correct section references. These will be moved in the committee stages.

Before I wrap-up my contribution, I wish to thank Cassy O'Connor for working with me and co-sponsoring this bill. It has been a tough time for Cassy in recent weeks with the death of her dad. I thank you for your work on the bill and for being so passionate on this issue.

I commend, personally, Cassy O'Connor and hope she and her family can deal with the situation they are dealing with at the moment as best as is humanly possible.

Lara Giddings goes on:

We could not have achieved what we have without the incredible and tireless work of Margaret Sing. Margaret has kept us abreast of developments overseas and interstate and worked long hours on the bill as well as helping to support its passage. Thank you to Margaret, particularly from Lara.

As politicians, we can no longer fail to listen to people suffering at the end of their life in our community. We can no longer use excuses that we support the principle but not this bill. By doing otherwise, we are condemning more people to suffer more pain, more indignity and for some, a lonely, often violent death as they suicide on their own.

There is no answer or one ideal model to follow. The Voluntary Assisted Dying Bill 2016 is safe and I strongly believe we have the balance right between protecting vulnerable people and allowing competent people, living with intolerable and untreatable pain, to choose an end to their suffering.

On behalf of Lara Giddings today, I ask for your support of this bill.

I congratulate Lara Giddings, who is standing down from parliament at the end of this term. I commend her for the work she has done in this parliament, particularly on issues like this that she has a strong, personal belief in. She has championed this cause for a long time. There is an opportunity for the Tasmanian Parliament to support this bill today and I say particularly to those members opposite who support the intent of this bill but have concerns about the bill, to support the bill into the Committee stage so those issues can be discussed, not just on the chance the bill may pass, but even if it does not pass that we have the opportunity to debate this legislation fully tonight.

We do not get many issues like this where you have the public gallery packed with people, where they have extra television screens brought in downstairs, chairs for people, and rallies out the front. The Tasmanian people on both sides of this argument want to see this bill debated. It can only be fully debated if it goes into the Committee stage.

This is about personal choice, about the way people want to see their own life end, the way people want to see their own family members have an opportunity for a dignified exit from this life. We know too often that people die in circumstances that can possibly be improved if this bill does pass. I urge all members of this House to support the bill. If you cannot support the bill, at least support it into the Committee stage.

Madam SPEAKER - I clarify for the House we cannot go into Committee, given the motion agreed by the House unanimously today.

Ms GIDDINGS - Point of order, Madam Speaker. The House can vote for the second reading. At some point we would have to resume to be able to go into Committee. It would be extraordinary to have a bill without Committee.

Madam SPEAKER - I suggest you read the wording of the motion. I have taken advice on this.

Ms Giddings - We have been done over by the Leader of Government Business, Madam Speaker.

Madam SPEAKER - Order. Members supported the motion unanimously. The Premier has the call.

[6.25 p.m.]

Mr HODGMAN (Franklin - Premier) - Madam Speaker, as Leader of the Liberal Party and the Government I confirm that all members of the Liberal Party are able to vote freely in accordance with their conscience. It is of course appropriate in again dealing with this issue and as has been the case in the past, and as I will do in accordance with my conscience and having paid careful regard to the breadth of views of members of our community on this issue.

I too thank all those who have personally shared their views with me, views which are diverse, complex, confronting and which might occasionally even appear a little self-contradictory. Many in our community have mixed feelings on a subject like this, and understandably so, as would also similarly be reflected in this parliament and in this debate.

We heard new perspectives from the newest member to join this parliament, Dr Broad, which were thought-provoking and added a new perspective to the debate which reminds us that it is an ongoing subject of interest and one with many angles and perspectives. It is a very confronting and challenging issue. I have no fear in saying that I am personally very confronted by it and heavily conflicted by it.

I have every empathy and sympathy for those approaching end of life and I have witnessed loved ones increasingly so at that point in life. It is excruciating. It is frustrating. It is heartbreaking and, like most people in our community, I yearn for a way where those who are seriously ill can be relieved of their pain. I instinctively support the notion that people should be free to determine their own future and control their own lives.

I, like everyone in this place, also have the added burden of the legislator, of advancing our community, but also of ensuring that our community and some within it, those who may be vulnerable, are not put at risk by what we do.

I, like most people, if you look at polls would support, in principle, the notion that people should be able to make decisions about ending their life when they are suffering a terminal or an incurable

disease. I believe also, as most including opponents of this bill, have said that we should also continue to work to better equip and support people to make decisions about their life themselves.

I have grave reservations around efforts to adequately and safely ensure the protection of people at a most vulnerable point in their lives. I am concerned about the nature of assisted dying being available to those with a non-terminal illness and those of a young age. I remain concerned at the risk of those vulnerable, say due to undue influence or coercion by others, those with a disability or those with a mental illness. Protection for these people cannot be guaranteed by this legislation as the proposers would concede. It is easy in theory but a lot less so in practice and it is we who bear the responsibility of legislating who have, we are told, to find that balance. It is especially confronting when we have an issue that is also not only dividing political groupings and those with a religious perspective but also legal practitioners and medical practitioners, well-respected doctors who are split on this issue, yet we are asked to legislate and define that balance.

Ms O'Connor - The AMA says it is up to us.

Mr HODGMAN - They would say, also, with due and careful regard to the consequences of what we decide in this place to their profession and to their ethical foundation, and to the responsibility that we would impose on those who may voluntarily or not, wish to participate.

There is a divergence of views, including amongst those more expert in these matters, notwithstanding the extensive consultation and work that has been done with respect to this particular model. It is but one, and I do not accept the suggestion as some have made that it is the only model that we can and should consider.

Why would we not benefit from inquiry that truly engages competing perspectives, that tests protection measures, assesses contemporary medical treatments, practices and developments including advanced care directives? Why would all those interested in this debate on both sides not welcome community led conversation informed by experts in this field? I understand and I have heard some are dismissive of the value of inquiring into these matters. On the other hand, they have also pointed to the process, the exercise undertaken, in Victoria as an approach that has been held up as an example of leadership.

It is a process that is not yet concluded and, by any measure, is a substantive inquiry into contemporary matters and the sorts of issues I have raised. While that has been identified as a substantive effort by another jurisdiction to take the leadership role -

Ms Giddings - We did that in 2013.

Mr HODGMAN - It has not been done here.

Ms Giddings - Yes, it was. Margaret Otlowski, Michael Ashby and others were involved.

Mr HODGMAN - What has happened in Victoria and what is happening in Victoria has not occurred here.

Ms Giddings - We had an expert group, as Daniel Andrews has.

Mr HODGMAN - We certainly have not had it with respect to this legislation.

Ms Giddings - It built off the 2013 one. It has been out for public consultation.

Mr HODGMAN - I believe it is an arrogant approach to suggest that this bill and this debate would not benefit from such a thing. Why is it the only option? A bill that still has unanswered questions by the Australian Medical Association and by the Law Society of Tasmania? Previously opposed, but unanswered questions raised by those groups.

Ms O'Connor - What is he saying about his colleagues in the medical profession?

Madam SPEAKER - Order.

Mr HODGMAN - Why is this bill being brought on for a debate with limited time, without affording this bill an inquiry or, at least, exposure to those competing perspectives?

Ms O'Connor - That is what the Committee phase is about.

Madam SPEAKER - Order.

Mr HODGMAN - It is being claimed, untested, that this bill has been improved on former versions but that is not apparently supported by groups such as the Law Society and the AMA.

Ms Giddings - The Law Society does not have a position.

Madam SPEAKER - Order, we have come to this point in relative silence. Please do not spoil it.

Mr HODGMAN - We are all being challenged by some people in this place to make a decision on this bill tonight and I cannot support it. It contains significant shortcomings. This bill and those shortcomings emphasises the difficulty in constructing a framework to safely provide for voluntary assisted dying, despite it being said it has been widely consulted, against a backdrop or context in which we are not alone. Currently there is no state or territory in Australia that has legislation to enable voluntary assisted dying, despite the number of states having repeatedly and unsuccessfully considered legislation. It has been tested and rejected here and in many countries and other sovereign states on numerous occasions.

The South Australian Parliament has rejected legislation for voluntary assisted dying 15 times, most recently in late last year when it was criticised for allowing those without a terminal illness access to assisted dying. A similar approach to it is being proposed here. It did not succeed. I remain incredibly concerned that legalising voluntary assisted dying through the mechanisms in this bill would not adequately recognise the vulnerable, the aged, those with a disability are those who might be under pressure, influenced or coerced by those close to them to end their lives.

How much someone is suffering is subjective to the individual's experience. How that can best be balanced, as the proponents suggest, is not clear. The question as to what is an eligible medical condition contains a subjective element, one that the bill does not provide guidance around. What this means in practice for medical practitioners responsible for identifying whether the person has an eligible medical condition is a concern.

I am confronted by the fact there is no requirement for either the primary or secondary medical practitioner to have met the requesting person before, or to have had any prior involvement in their care. This places the medical practitioner squarely at the centre of a decision that results in the death of a person. That primary medical practitioner is being asked to make assessments of a person's mental state, which is an incredibly onerous task and one that GPs, for instance, are not necessarily trained or prepared for.

The use of the term 'voluntary' can raise ambiguities through its applications within this bill. It is not clear, for example, whether the bill is intended to enable a person who will eventually lose competence over time as a result of their condition to make an assisted dying request to be acted upon once the person is no longer capable of communicating, for instance, as per an advance care directive.

The scope of the bill has broadened, as has been acknowledged by the proponents. The definition of an 'eligible medical condition' contained in this bill is broader in application than what was before the parliament in 2013 including, it would appear, those with non-terminal conditions. That is a significant concern to me.

It is also not clear whether the bill provides medical professional oversight or a structure for the reporting of end-of-life decision making, which is also an important issue to safeguard and ensure a robust and defensible decision-making framework. There are a number of issues associated with the way the bill deals with issues of competence. I will flag a number of them that concern me.

First and foremost, the meaning of 'competent' appears to establish a set of criteria that are different from other key acts, including sections of the Mental Health Act 2013, sections 7 and 8, which define and regulate decision-making capacity and informed consent. Section 36 of the Guardianship and Administration Act 1995 identifies when a person is incapable of giving consent to the carrying out of a medical or dental treatment.

The bill also appears to reverse the presumption that at law every adult is presumed to be competent to make decisions unless there is clear evidence or knowledge they are not. It is not clear how a medical practitioner is to form a reasonable suspicion or whether the practitioner is required to have any clear evidence or knowledge to support the view that a person they are seeing is not competent to make an initial oral request for an assisted death.

This suggests that the purpose of referral for counselling is to determine whether the person is competent that, if correct, would suggest the presumption in favour of capacity is reversed in this component of the bill. It is also unclear as to whether the bill adequately contemplates consideration for the challenges associated with enabling communication through a third party, which would require one person to interpret another person's wishes. This is fraught with risk.

The term 'diagnosed' is defined to mean diagnosed by a medical practitioner. What is not clear is whether the bill requires a person to be diagnosed by a medical practitioner who has specialised qualifications or experience in diagnosing and treating the person's medical condition, by the person's primary medical practitioner or both. These are some matters of concern to me and to members in the community. They are matters raised and would best benefit from further inquiry. They would best be informed by perspectives offered by those with expertise, not only those of the proponents of this bill, which we are being asked to do.

I note, without revisiting some of the detail provided in this debate by other members, the considerable work and effort being undertaken in strengthening our effectiveness in palliative care treatments. I recognise they are not perfect and nor do they cover each and every scenario. There is the development of a palliative care framework. I acknowledge the work of another parliamentary inquiry and its committee and the government to advance our efforts in establishing an overarching strategic direction for palliative care policy in our state. Progress to consider the developments of advance care planning for the end of life, should people wish to do so, is an equally important element of the debate, as are the other matters referred to in the amendment moved by Mr Jaensch and the work that has been done in other jurisdictions to inform this debate.

As other members have done in this place, we can all draw on our own personal experiences and they can influence our thoughts, our consciences and the way we vote. It is entirely distressing for us to

witness first-hand, and even if we have not, to hear of experiences of those whose end of life has been painful, traumatic and the cause of great distress not only to the individual but those close to him or her. It is without doubt an element of this debate we can all share and draw upon as a common experience that might inform our decision-making and thought process as we again debate this matter. Matters of personal experience, and a widely held view that we should be able to determine our own futures and make decisions about our end of life are often canvassed and the broader public does not reduce the significant burden that we bear as legislators, each and every one of us. It is a burden and an effort taken by the proponents to develop this bill, one which we are each being asked individually to vote upon tonight.

The substantial nature of the criticisms of this bill, which are not just criticisms of members in this place but those in the broader community and those with expertise I have referred to, cannot be understated or denied. In my case, it is impossible to ignore them, given the nature of the subject matter we are debating, notwithstanding the imperative that some might have for us to conclusively determine one way or another whether this bill should pass tonight.

The parliament should not be expected to pass legislation that is deficient in ways that might expose the vulnerable in our community, and I do not believe the bill, in its current form, is worthy or can adequately secure my support. It is arrogant for some to say that people who might support the principle can only support the bill, given the nature of this subject matter and the various deficiencies or concerns that have been raised in relation to it. If those proponents had demanded the bill must be supported or not, as is the case with any bill that comes before us, I will certainly oppose it on the basis of inadequacies I have referred to including the lack of safeguards it provides.

I will not dismiss the notion that this matter, which is so important to members of our community and much more important and deserving than a show of political brinkmanship as has been suggested by some today, cannot be advanced positively through further inquiry. It is far too serious to get wrong simply because some have said we are elected here to make a decision today. If this bill fails to pass, I expect the issue will come before future parliaments and I pledge to make a positive contribution to the debate. I do so from a perspective that I believe we should empower people to have more control over their lives. Palliative care does not provide an adequate solution to all who are suffering from a terminal illness and there is worth in progressing the development of measures such as advance care directives. A future parliament might be able to consider a bill that more effectively and safely provides for voluntary-assisted dying than this one.

I will not support the bill but I will pledge as far as I am able in whatever capacity that might be to be part of that community debate.

[6.45 p.m.]

Mr GROOM (Denison - Minister for State Growth) - Madam Speaker, I appreciate the opportunity to make a contribution to the debate. At the outset I acknowledge all the contributions that have been made so far and also acknowledge the efforts of everyone who has been involved in this debate, including those who have brought this bill forward. I know there are many people who have worked tirelessly to advance what they believe is law reform that can add dignity to those suffering at the end of life. I respect that and recognise their efforts.

I also acknowledge the sensitive and considered feedback I have received from hundreds of constituents on both sides of the debate. People have written to me both in support of and against this bill with, in some instances, heart-wrenching accounts of their own personal experiences, illnesses that have been suffered by members of their family and ultimately very difficult deaths in their families. I very much acknowledge that.

As a member of parliament you have lots of engagement with constituents on many issues, but there is no doubt at all that this type of issue gives rise to a slightly different type of engagement. I really appreciate the extraordinary effort that some people go to to express their views. I acknowledge that they have helped me enormously in attempting to reconcile the various perspectives on this particular issue.

There is no question at all that there are strong views on both sides of the debate. We should expect that to be the case, given the fact that we are dealing with matters of life and death, as everyone has recognised it is a very complex and difficult issue.

However, I cannot support this bill specifically and I also continue to have great difficulty in accepting the concept of state-sanctioned voluntary assisted dying. There have been references to polls and positions that have been surveyed in terms of views in the community. While the feedback I have received personally is probably 50:50 for and against, I recognise there are many people in our community who have some empathy for the concept of this type of legislation. I have reflected on it and the contribution I made the last time we had this debate. I consulted, I have thought and I continue to struggle to get my head around the concept of the state being involved in voluntary assisted dying.

The main core of my concern is the potential for it to have adverse consequences for vulnerable members of our community. I cannot understand how it is through legislation of this kind that we can be comfortable that there will not be adverse consequences for vulnerable members of our community. As a consequence of not being able to accept that concept broadly I do not support the amendment put forward by Mr Jaensch in taking this to a committee process but I very much recognise the very genuine effort that Mr Jaensch has put into this. I thought it was slightly unfortunate that he was attacked for that effort. He is a good man and has made that suggestion in good faith and in a way that is consistent with the values that he holds. I respect that effort.

I acknowledge there are real issues at stake here. It is an undeniable reality that for some the process leading up to death can involve very significant pain and suffering and a strong desire for relief by the individual and close friends and family on that individual's behalf. As has been acknowledged with the contributions so far in the debate, we have all had different life experiences. Some have had very direct exposure to these issues. I have had some exposure, but I suspect not as direct as others. I genuinely respect the real suffering some have to endure. I acknowledge that even with the best available palliative care, that does not completely remove that.

There is another side to that ledger, which is the potential for this type of law reform to result in a vulnerable member of our community being encouraged, persuaded, motivated or manipulated into a decision to end their life. That is something I cannot get my head around and that is at the core of my concern.

I strongly believe we need to do more to improve the delivery and effectiveness of palliative care. It is important we recognise the extraordinary efforts put into palliative care by those who work on the front line, the extraordinary compassion and care they offer for people as they experience the period leading up to end of life: the doctors, the nurses, the aged care specialists; many people are involved in that effort and on behalf of our community, we thank them for everything they do for those individuals.

This law can have a massive impact on those who are involved in the front line. We should listen very carefully to them as they have practical experience in dealing with these types of issues. It concerns me that when considering this type of law reform, there are many people who are on the front line who have a real issue with this legislation.

I want to go through a number of my concerns in the time I have available. I will mention briefly some of the legal or technical issues I have with the bill.

I believe it was Ms Ogilvie who raised the potential for there to be unintended consequences through the interaction of this law and the existing law, including the Criminal Code and various other acts. Often there can be significant unintended consequences and it is very important serious attention is given to how a law like this would interact with well established legal principles and the existing Criminal Code and other relevant legislation.

Ms O'Connor - There is a specific provision in there, a doubt removal provision in relation to the Criminal Code.

Madam SPEAKER - Order.

Mr GROOM - I continue to be of that view. Ms Ogilvie mentioned the potential for there to be uncertainty in the existing law and there are fair points that have been made in that regard. What we do not want to do is make it worse or add to it. That is a very important point.

A number of concerns have been raised in relation to the definition of eligible medical condition and also that it now extends to non-terminal conditions. I concur with that. The potential for there to be legal dispute, often involving family members at a very difficult time, is a very real issue and one that causes me concern.

I struggle with this notion of an age restriction. If you were to be supportive of this concept in principle, I do not understand how it is -

Ms Giddings - It should be competency based.

Mr GROOM - I do not understand how you would have a law that says for an 18 year old you can have the benefit of this, but if you are 17 you cannot. That gives rise to serious questions about how this law would apply if it were to extend to people under the age of 18 in terms of consent. There is the potential for vulnerable members to be taken advantage of in our community. They are very real and significant issues.

I acknowledge that those who are presenting this bill have come at it from a perspective of compassion. We must also have compassion for vulnerable members of our community who might feel pressured, such as the elderly, the lonely, those without family, those who are depressed or with mental illness, the destitute, those who are exposed to other vulnerabilities. There is no doubt that this bill provides no guarantee that we will not see an example of a vulnerable member of our community being abused through the process that is established by this legislation.

In fact Ms Giddings admitted as much today on ABC radio when she said, and I will quote:

There is no perfect model. We are developing a model, and it has been developed over some years now, that we believe is safe that will look after vulnerable people, but why is it just because there is a risk, a very small tiny risk, that a vulnerable person might be hurt through this process, that many many more people have to continue to die agonising deaths?

I will cite that in reverse because if there is a risk that a vulnerable member of our community could be led to a death by virtue of the fact that someone has taken advantage of them -

Ms Giddings - There's a risk a bus will knock you over when you leave this building.

Madam SPEAKER - Order.

Mr GROOM - or manipulated them into that decision, then I believe that that is a risk that is too great. When you are talking about someone's life I believe that that is a risk that is too great. I cannot be a party to the passage of a law that would facilitate the end of a person's life, sanctioned by the state, in circumstances that are not appropriate. I cannot understand how it is that we can provide a protection against that type of abuse.

I also have concerns about the potential this has to send mixed messages to people who might be vulnerable to suicide. We have had a lot of talk, in this place and in the broader community, about many members of our community who can reach a low point in their life and not necessarily see value in continuing, see a way forward. It is important to recognise that there are many, many examples of people who move through that process and who then go on to live very meaningful lives and very enjoyable lives and take a lot of satisfaction from that life. It is important we send clear messages to people that what we want to do is be supportive of people who are experiencing those sorts of feelings.

It worries me that this type of legislation has the potential to send mixed messages. This is also relevant in the context of people who might be suffering pain or dealing with an illness, including a terminal illness. I quote from a British inquiry some years ago in relation to the concept of euthanasia. The quote is from Dr Nathanson at the British Medical Association. Dr Nathanson practised in this area and he spoke about the feelings people often have when they are dealing with end of life issues. This is what he said:

Many patients who raise questions about the end of life and **euthanasia** or suicide, sometimes in very heavily coated ways and sometimes more explicitly, are very often asking quite simply, 'What services will be available if I develop symptoms that I cannot accept, that are intolerable to me?', and it is not always pain. It is very important to realise that symptoms that people are most worried about are very varied. They want reassurance. I remember well one patient saying to me very explicitly, 'What I want to know is that I will not be abandoned'. There will not be a stage at which people will say, 'There is nothing more that we can do for you'.

That is a very important reassurance to give, to say that we do not abandon people, and that we will always look for what else we can do. Sometimes those solutions are high technology that very often are low technology and are about reassurance. Again, I acknowledge the effort that those who are involved in palliative care do in that regard. It is a very important part of the support that they provide. Very often it is psychological support; helping people to come to terms with what quite clearly has been a devastating diagnosis with devastating news at the end of a process of treatment. It is important that we are sending the right messages to people that we will not abandon them. That is a really important point.

As I have acknowledged we have had the recent inquiry in relation to palliative care and we recognise that we can do more. We need to make sure that we are looking for ways to offer the best possible and most effective form of assistance to people who are dealing with these types of issues through the delivery of palliative care. I acknowledge that there have been a number of recommendations, including legislative arrangements for improving the effectiveness of the delivery of palliative care and legislative arrangements relating to advance care plans. The Government will give very careful consideration to those recommendations.

I acknowledge also the potential for this to have an impact specifically for the elderly in our community. There are current national inquiries going on into the concept of elder abuse. I remember hearing some quotes recently from someone who has been involved in the current national

inquiry where they were citing examples of some of the practical abuse that older people in our community go through. There was one incident where the son had moved into the house to renovate it and then subsequently sold the house and nicked off with the money. There was another one where an elderly person had gone to the bank to take out \$50 000 and when questioned by the bank manager conceded that she was doing it because she was being threatened by her son that she would be denied access to the grandchildren.

These are some of the harsh realities that vulnerable older people in our community deal with on a day-to-day basis so we should never underestimate the potential for this type of process to be abused. While the vast bulk of our community is very decent and provides a lot of love and support for older members of their family there is unfortunately a cohort in our community who do not have good intent and would seek to take advantage of these types of processes.

I continue to have a concern about the potential impact these types of laws might have on the doctor-patient relationship. It is a very special thing that doctors have a clear obligation to make sure that they protect life. The potential for this to put doctors and nurses, medical staff and other people again at the front edge of these types of issues in difficult positions, with mixed messages in what their underlying obligation is, is quite real. It continues to concern me that so many members of the medical profession continue to express concern in relation to this type of law reform.

I acknowledge the genuine intent that I believe those that have brought forward this legislation have. I genuinely respect the different views in this Chamber and also that we see in the broader community. I cannot support the legislation though given the fact that I cannot see how under this specific bill, or frankly I cannot see how under this type of law, we can protect vulnerable members of our community from being mistreated or abused through the processes that are established. On that basis I cannot support this legislation.

[7.04 p.m.]

Mrs RYLAH (Braddon) - Madam Speaker, I acknowledge and respect Ms Giddings and Ms O'Connor for their motivation to relieve suffering. I thank the people of Tasmania for the hundreds of emails and calls regarding this bill and the submissions to the Palliative Care Inquiry as they have helped to inform my view. I recognise the wonderful work of frontline workers. I also thank my Palliative Care Inquiry Committee members for such an inspiring and enlightening inquiry: Ms Ogilvie, Ms Dawkins, Mr Jaensch and Mr Brooks.

A prime responsibility of a parliament is to pass laws that are for the good of the common people. When considered from a social perspective the parliament creates laws to protect the vulnerable people in our society. I wish a parliament could end suffering for anyone, for everyone, by passing a law. That is a fantasy, an impossible and false hope, albeit a very compassionate aspiration, but a totally tragic building of false hope.

As a parliamentarian it is my responsibility to use wisdom over emotion in considering not only the intended effects of legislation, but very importantly the unintended consequences of that bill. No matter how emotive the stories and experiences, this debate will not resolve the issue, nor will it end suffering I will contend, nor will physician-assisted suicide. Physician-assisted suicide, it is very clear from the evidence we have that death by injection is not guaranteed to provide a quick, fail-safe death. Furthermore, and most importantly, this bill would bring about irreversible change to medical care, harming future patients. On this ground alone I do not support this bill.

I want to ensure vulnerable Tasmanians do not lose the protection they have or the importance of their full lives in our society, no matter what it looks like and whether it involves suffering. The bill before us here today, which can be paraphrased as putting into law the right to kill and the right to demand to be killed, consideration of the bill requires the application of deep thinking and wisdom to protect the

vulnerable and future vulnerable people in our society. People without a voice, the weak, those not part of the educated elite, the elderly widows or widowers and especially the disabled, whether born with a disability or as a result of injury or illness: these are just some of the vulnerable our society must protect and value, and these are the people I am thinking about.

Ms O'Connor - What about the vulnerable people who take their own lives out of desperation?

Mr DEPUTY SPEAKER - Order, Ms O'Connor.

Mrs RYLAH - This bill is not about the act of dying, as the title proclaims. That is the outcome that is being sought here. Instead it is about how to bring about death, specifically how to bring about another person's death with clear and intended intervention. That is, to bring forward death of another human being, to kill, to kill with intent. In law, this form of killing is murder.

This legislation wants to put into law that doctors and nurses will medicate with the intent to kill. The issue in this bill is the critical matter of intent put in place a right to kill, a right to be killed and the end consequences of putting those positions which then becomes, as the European experience shows, a duty to die.

This is particularly true where the person has developed or have an eligible medical condition, using the words of this bill, in the advanced stages of serious, incurable and irreversible medical condition. This concerns me greatly. It concerns me that this bill does not require a witness-signed authorisation by the patient.

Ms Giddings - Yes, it does. You have to have two witnesses.

Ms O'Connor - Have you read the legislation?

Mr DEPUTY SPEAKER - Order.

Mrs RYLAH - For me this bill further fails because the definition of who is eligible is not clear.

Ms Giddings - This is the problem when you don't read the bill and you don't know what you're debating.

Ms O'Connor - That's exactly what has happened consistently today.

Mr DEPUTY SPEAKER - Order.

Mrs RYLAH - I turn to the issue of who is vulnerable. The protection of older Tasmanians, particularly women, any disabled person, the terminally ill and those who someone could describe as suffering unbearably are more, not less, vulnerable should this bill pass.

Ms O'Connor - What a load of garbage!

Mr DEPUTY SPEAKER - Order.

Mrs RYLAH - I will say that again. Older Tasmanians, particularly women, any disabled person, the terminally ill and those who someone could describe as suffering unbearably are more, not less, vulnerable should this bill pass. This concerns me greatly.

Ms Giddings - Justify that statement.

Mr DEPUTY SPEAKER - Order.

Mrs RYLAH - In an *Age* newspaper article Professor Hickie, a psychiatrist and mental health campaigner of the Brain and Mind Centre was quoted as saying -

Australian authorities needed to work on policies and resources to promote healthy ageing with a focus on getting the right care and support to people so they do not feel like a burden and live as well as they can in their later years.

... people considering suicide or a family discussing the issue should examine what is underpinning the person's motivation for suicide. Is it fear of being a burden? Is it fear of lack of care?

Professor Hickie thought it was tragic that people wanted to check out of life because of myths and negative stereotypes about ageing, pain relief, hospital and how the health system treated elderly people.

Our role is to ensure every person receives the best available treatment and is treated equitably. There cannot be a preferred status or a class of people - specifically the younger, non-disabled, educated, verbal and healthy. These are the elite under this bill. I do not support elitist and exclusive treatment of any kind or treatment of people in our society -

Ms O'Connor - People living with a disability could access this bill. Don't treat them like second-class citizens.

Mr DEPUTY SPEAKER - Ms O'Connor, order.

Mrs RYLAH - and on this basis I do not support this bill. There are no robust checks and balances in this bill. I believe it would immediately be seen by those vulnerable people that these young, healthy and pain-free are better, have a more worthwhile place in our society and perhaps it would become more worthwhile to receive treatment. I am reviled by that thinking. No matter how old, how disabled, everyone should be entitled to funding and health services. This bill -

Ms O'Connor - Which you haven't read.

Mr DEPUTY SPEAKER - Ms O'Connor, if you cannot sit there without interjecting I ask you to voluntarily leave. If you continue to interject, I will eject you.

Ms O'Connor - Thank you, Mr Deputy Speaker.

Mrs RYLAH - is somewhat of a mixed bag, a dog's breakfast. It is nowhere near ready to become law because of its inconsistency in drafting, apart from the fundamental moral issues it seeks to upend. I will not support this bill.

I turn to the issue of suicide. Our role must not, and cannot, be to provide suicide as an okay thing to do by anyone. We all know from the evidence that suicide ideation is transferable. Who in this House would like to see more youth suicide? The answer has to be a resounding no. We must not promote a double standard on suicide; prevention on one hand and on the other the promotion of suicide, as this bill offers.

This bill puts a dangerous weapon in the hands of those who indulge in elder abuse, those pressuring disabled people or older people to ask for assisted dying. I draw to the House's attention the Criminal

Code prohibition on assisting in suicide is not about protecting the family or caring and compassionate others. It is about protecting vulnerable people from being coerced or coaxed into their suicide death for the issue I espouse. It is dangerous. UTAS Senior Lecturer of Criminal Law, Dr Jeremy Prichard, argues that it is difficult to identify the outward pressures from other people that lead to suicide euthanasia.

This bill does not address this problem of pressure from family and others leading to requests for euthanasia by vulnerable people. The huge rise in elder abuse to date as outlined by my colleague, Mr Barnett, and the inability in our laws to stop this so far is very clear.

The issue of coercion was a criticism of the previous bill and as Mr Llewellyn stated is not addressed in this bill. There is an alternative and that is palliative care, an alternative that does not promote a double standard on suicide. Having chaired the Parliamentary Inquiry into Palliative Care I have heard first many of the issues and concerns about end-of-life choices and the need to empower individuals and to have an open and public discussion about death and dying. Our report said -

Fundamentally it recognises a need for an informed and planned end-of-life period where individuals can have greater certainty and knowledge. The overwhelming evidence from experts and witnesses is a desire by individuals for greater control of that care plus a desire to know that the care they wish to receive will be supported and thus one can be reassured. Further, that patients will be protected throughout palliation including in their care choices.

In a recent article by American ethicist, Ezekiel Emanuel, in the *Medical Journal of Australia* said -

We should end the focus on the media frenzy about euthanasia and PAS (physician-assisted suicide) as if it were the panacea to improving end-of-life care. Instead, we need to focus on improving the care of most of the patients who are dying and need optimal symptom management at home.

The palliative care inquiry made 26 important recommendations. One of those is to improve advanced care planning. The committee heard from Alison Lennox who spoke of the benefits experienced as a result of both of her parents having advanced care plans prepared, appropriately communicated and respectfully implemented:

Both my parents had written Advanced Care Directives with the help of family and their Doctor. I had happened to hear about the importance of ACDs when my Mother was still in reasonable health and as a family we could talk to her about what she hoped for her end of life care. My father at that stage decided he should be involved too, so happily both had Directives in place as their lives faded.

My mother died in hospital in 2013, but the spirit of the ACD was followed and Mum was kept comfortable and pain free as she faded from this world. I was with Mum and was taken aside in the first 10 minutes of her admission to ED to check that I was 'happy' with the ACD and to be informed that it would be followed. Mum died about 8 hours later without pain, but also without treatment (antibiotics) which may have prolonged her life, but left her unable to live independently ever again, if she survived. This was exactly the scenario we had planned for and it was a blessing that she could sleep pain free and then die peacefully. Mum was a frail 89 year old.

My father died two and a half years later. His ACD was respected and Palliative Care 'administered' to ensure he didn't suffer from the painful and traumatic effects of seizures which would have ensued, caused by a brain tumor (melanoma). The palliative care he received was of the best quality, with information given freely and truthfully to family members if needed. We were happy to see Dad die with peace and pain free. He was 91.

After this experience, I too have completed an ACD, which I will of course have to update regularly, and I encourage all my friends and family to do so to.

My hope is that with more talk and information it will become the norm for people to complete ACD's. I do remember that even one GP we talked to about this issue didn't know where to access any forms about ACD's. Luckily we kept asking and found the information we needed.

Let us hope ACD's and discussion about Palliative Care mean that lives can end with dignity and peace, without the negative hype produced when Euthanasia is mentioned.

There is a major ethical difference when we examined in detail between a terminally ill person making their own competent and conscience decision to decline further life-prolonging and sustaining treatment other than pain relief and as a consequence of those decisions accelerate the progression to a natural death. Euthanasia means to authorise in law the killing of a person with an incurable medical condition.

The bill as proposed places medical practitioners, pharmacists and nurses in an appalling position of doing something entirely inconsistent with the tenets of their profession, an ethical dilemma for many of these medical professions, which I believe would cause great fear. As the bill stands, a patient could request euthanasia even though palliation would be a better option. It is safer and less traumatic and ethical for the medical professionals involved.

We need to have a way to assist those people who have a terminal and debilitating condition and may want to end suffering. Far better to give them the choice of a natural death, even if that death is speeded up due to the refusal of further treatment or the administration of pain relief. A compassionate response is already available in Tasmania with advance care plans whereby a person can competently stipulate exactly what they would like done in their own case. With the recommendations of our report on palliative care there will be much more certainty for people facing end-of-life issues and decisions.

I do not support this bill because it does not have safeguards to protect vulnerable people from pressure and coercion. It will set back the cause of human and palliative care. It promotes suicide and places medical professionals and pharmacists in an appalling ethical condition.

What I support is palliative care which is compassionate and holistic care involving ongoing sensitive communications with individuals involved in decisions about their own and their loved ones treatment and care. Getting education to understand the early entry to palliation and early care for pain and symptom management is essential. We need to do everything not to cause fear of medical care, however irrational that concern may be.

E J Emanuel, whom I quoted earlier in my speech tonight in his paper 'Euthanasia and Physician-Assisted Suicide - Focus on the Data' notes that euthanasia and PAS are rarely used. He goes on:

These data mean that the claim that legalising euthanasia and PAS will solve the problem of poor end-of-life care is erroneous. Euthanasia and PAS does not solve the problems of inadequate symptom management or improve palliative care. We need to deal with the problem that confronts most dying patients - how to get the optimal symptom relief and how to avoid the hospital and stay at home in the final weeks. Euthanasia and PAS is really a sideshow in end-of-life care.

He outlines the importance of psychological suffering as patient's rationale for requesting euthanasia and more like traditional suicide. He finds that psychological reason dominate. At the end of his paper he raises this question:

What is, then, the great impetus to legalising interventions to end lives for a small minority of patients who are depressed, worried about losing autonomy and being tired of life?

His answer from the huge amount of data he reviewed is:

We need to focus on improving the care of most of the patients who are dying and an optimal system of management at home.

While Mr Jaensch's amendment shows his empathy and desire to relieve suffering, I do not support this bill being used in an inquiry. I support the funding and provision of increasing excellence in palliative care for all Tasmanians no matter where they are located or their circumstances. I want to support and find ways to reduce fear and the loss of control, depression and better symptom and pain management. We must give people the tools to have control so that they know their wishes will be followed at their end of life, actions like the legal regulation of advance care plans, to enact legislation to formalise the common law doctrine of double effect and the legal protection for doctors regarding withdrawing and withholding futile treatment.

As a 16-year-old I watched a lady die in front of me in hospital where I could not get out of bed or help apart from scream to get nursing help. She had suffered undoubtedly with her cancer and I only knew her in those last two weeks of her life.

Time expired.

Ms GIDDINGS - Point of order, Mr Deputy Speaker. If you can clarify a standing order. My understanding is that there is the opportunity, if members vote to go into Committee at some point, that we can indeed do that but it will just be on another day. There is the opportunity if people support the second reading to go into Committee.

Mr DEPUTY SPEAKER - Point (d) of the motion states that following a vote of such question further proceedings of the bill, if any, shall be made an order of the day for tomorrow.

[7.25 p.m.]

Mr GUTWEIN (Bass - Treasurer) - Mr Deputy Speaker, I am pleased to have the opportunity to make a contribution on this bill and to say that conscience debates generally are some of the best debates we have in this place. I must say that some of the tone of today has not been perhaps what it has been in the past but that is a matter for those who are engaging in it. I make the point that in here there will be different views and out there in society there are different views. We are fortunate that we get the opportunity to stand in this place and place on the record what we think. Not that our experiences are any greater or lesser than anybody else that lives in our community, but we have the opportunity and we should recognise the privilege we have and the fact that we have an even greater privilege when it is a conscience vote.

Everyone has a story. I want to note, as other members on both sides have done, the significant contribution that many constituents have made, both for and against what we are talking about tonight. In reading the contributions from both sides you could not help but be touched if you had an ounce of compassion in respect of the stories people have shared. I thank people for that.

No-one can speak in a debate like this without being forced to think back on their own personal life experiences. I know this matter has been before the parliament before. It certainly caused me great reflection in regard to my own life experiences. Whilst those experiences are no greater or lesser than

anyone else's experiences, they are mine and are what have helped train my own thinking about matters such as this.

When I was giving some consideration to the matter before us it caused me to reflect on things that have happened to me, especially most recently the last half dozen years or so. Some in this House are aware that I lost my father to pancreatic cancer. Many in this place have lost parents. I had the enviable opportunity at the time, and it is something I am incredibly thankful for, of helping to nurse him through that period. My mother lived at Sheffield, I lived in Launceston, and palliative care was provided at home, so I used to stay with my parents and helped with the care for dad on weekends. That was in fact the first insight I had into palliative care.

I was touched by what you had to say about Mr Denman. The care and compassion those who work in that sector have is extraordinary.

Ms Giddings - It is not in dispute.

Mr GUTWEIN - The only way I can describe it is extraordinary. There is nothing you could call a good death. At the end of the day it is a death and there are consequences. We all struggle with grief, we all struggle with the questions as to what we may be should have, or could have done or said: at the end of the day someone has died.

My experience with my own father through that and pancreatic cancer is a particularly nasty and aggressive form of cancer, as people know. I watched a very healthy, robust, 69-year-old deteriorate very, very quickly. What I did experience through that was that whilst losing him - and I would never describe a death as a good death - the way that he was managed was very good. At the end of the day the last time I saw him was on the Sunday night of the week that he died. I had carried him to the toilet and assisted him and took him back to bed. Difficult, and as ill as he was in the way that he was feeling at the time, with the assistance of the palliative care nurse I know that he was being well looked after. What struck me about him is that even in that state he still wanted to live.

We can only talk about our own experiences and we can share those, as other people have shared with us in this place. I had the unfortunate situation occur only six months later with my younger sister, aged 43, with three young kids. She went to see the doctor, thought that she was depressed after my father's death, wasn't eating, and losing weight. She had an ovarian cyst the size of an orange. It had spread to every part of her body. I did not help care for her as she was living in Melbourne. She was a solicitor. My mother went across and you can imagine how difficult that would be. Dad had gone and the next thing Trudy is ill.

Again, through that and it was difficult and the circumstances were not good. She had a tougher going than my father did. I remember I had left the gym on a Saturday morning at 7.30 and picked up the phone and three calls from my mum and I thought, 'Gee something is not good here'. She said you have to get to Melbourne, the doctors want to talk to us mid-morning and they are going to ask us to make a decision. I got there and in fact I was late. They still managed to run late and I missed the conversation with the physicians, but the family had waited until I got there, so I could be part of the final decision. I had a chat with them. They said there is no brain function and we need to remove her off the machine and you need to make that decision as a family. We can keep her alive as long as you want.

I had a conversation then with my family. What was interesting was when my mother was talking about what we should do as a family and what was the right thing, and she was discussing what had happened to Trudy for that last six-month period and the care. Again, the message from mum at that time was the palliative care had been - if I use the word 'successful' that is probably in the wrong context in the circumstances that we had arrived at - but it had helped and it had worked and she had had a reasonably good period in respect of pain and pain management.

The reason I share those couple of experiences is - and when you speak in a debate such as this you cannot help but think back and reflect on your own experiences and the things that influence you - my experience with palliative care has been much better than I would have ever imagined it could be. That plays into my thinking in regard to this.

The last time I made a contribution on this, one of the things I said, and it has been said by a number of people in this place today, with most things we all want to have some degree of control over our own lives, and I am no different. I said in the last debate that if faced with intolerable pain I think I would want to have the option.

The difficult thing with this - my views have not changed since that time in regard to the guarantees - you would hope that everybody acts with pure motives but we know people do not. When you look at the law profession that makes a living out of managing estates after people have passed away and the difficulties they have with the distribution of assets and the way families can turn on each other, it is difficult to believe in cases where there were vulnerable people that people would not exhibit those same sorts of human traits.

Ms O'Connor - Can I just ask you respectfully, have you gone through the legislation clause by clause?

Mr DEPUTY SPEAKER - Order.

Mr GUTWEIN - I have read the bill. From the point of view of a bill before this place, it has been a good effort you have put in.

Ms Giddings - Do you think two doctors will put their name to allow someone to die?

Mr DEPUTY SPEAKER - Order, you know that is not allowable. Interjections should cease.

Mr GUTWEIN - I am happy to engage on it. One of the things I found through the correspondence I received was there are different views from doctors, the legal profession, the community. There are strong and passionate views on both sides, but I cannot bring myself to a position where I feel you can guarantee there are complete fail-safes.

Ms O'Connor - But right now people are being made vulnerable. Doctors are making decisions; people are killing themselves.

Mr GUTWEIN - This is the point I am making. Under this legislation people will still be vulnerable. Until a bill can be brought forward that provides that guarantee on an issue like this where there is no second chance, you cannot come back and try again.

I do not want to go back through a lot of the other arguments and points that have been made today but I want to be absolutely clear. This has forced me to think about a lot of things I had boxed up and thought I had dealt with completely. As you start to work through these things you start to think about these matters. It can be a very personal thing you have to deal with as to how you manage your way through and arrive at making a decision.

On one hand, as I have said, in every aspect of my life I like to be in control and in respect of my death I think I would like to be in control as well. But on the other hand I cannot bring myself to believe that we can craft legislation that can protect, with all of the necessary safeguards, legislation that will protect -

Mr Bacon - It can never be done.

Mr GUTWEIN - I am happy to continue the debate but I have yet to see a model I am satisfied with. Therefore, Mr Deputy Speaker, I cannot support the bill. There is no doubt that legislation like this will come back before the parliament. There is no doubt the debate will continue. As I have said, I would like to be in a position where I could personally have that control, lawfully, over my own end of life, but I would need to be convinced there were sufficient safeguards to protect against the motivations or manipulations that might occur with vulnerable people.

[7.41 p.m.]

Mr STREET (Franklin) - Mr Deputy Speaker, when I decided to put my hand up to run as a member of parliament I always knew that this would be the most difficult issue I would have to make a contribution and decision on. Very quickly to Dr Broad, I have had at least since November last year when this was tabled to start to get my head around it, so for a member to have only been in this place six weeks and get their head around all the issues in play and to make the contribution you made was an absolute credit, given the limited time you have had with this issue.

As people who know me well would tell you, Mr Deputy Speaker - and I hasten to add that that does not include anybody in this place - I have a very black and white view of the world. Even though I am conservative on some issues and moderate on others I am very black or white in most of my opinions. The reason this is the most difficult issue I have had to face is that this is one of the few that is grey for me, for all the reasons everybody else has talked about. However I also want to be in the room where these decisions are made, whether that is in the party room where Liberal Party policy is framed and discussed and shaped, or whether it is on a conscience issue like this in the Chamber. I want to be here making these decisions.

While it might seem trite to quote a television show, there is an episode of *The West Wing* that came back to me when I was thinking about this. It involved the staff in the White House trying to shepherd the President from a decision that was going to be difficult to make and they were trying to work out how to keep him out of the Oval Office, keep him out of the building and away from the situation so he would not have to make a decision. He found out about it and called his staff into his office and said, 'My basketball coach always told me that winners want the ball. Whether you're good, bad or indifferent, winners want the ball'. What he meant was, 'Do not ever shepherd me from hard decisions. I want to be in the room when those decisions are made', and that is exactly how I feel standing here today.

I made a conscious decision to seek out more people who were against the bill than were for it. There was not a single person I knocked back who asked for an appointment in my office, nor were they asked before they were given an appointment whether they were for or against the bill; what angle they were coming from. Like everybody else I have received countless representations, both in person and via email. To the people who emailed me, everyone of those people has received a response from my office but it has not come personally from me. I hope they understand that while I had time and made the effort to read through every single email representation, there simply was not the time to reply personally to each one and to address all their issues. I hope the people who took the time to email me understand that.

I must admit, the people who have come to see me about this issue have done a very good job of separating their religious beliefs from their representations and discussions. That is not to say that their religious beliefs do not shape their opinion and the way they represent themselves, but they have kept it separate from their reasons to disagree with this bill.

Some people might know I come from a fairly strong Catholic background and I must admit that I envy people who have faith because it must give them some comfort in their thought processes and

their daily lives. Faith is one of those things, unfortunately for me, that slipped out of my grasp and eluded me and I have never been able to get it back, try as I might.

In assessing this bill I am concerned about vulnerable people, the aged and the disabled. A bit over 12 months ago I stood in this place and made my maiden speech where I said that one of the fundamental tenets of my beliefs was how we best care for those who least able to care for themselves. That has weighed heavily on my mind.

One of the other arguments that has been presented to me a great deal is the slippery slope argument and people quote the Netherlands and Belgium. I understand that but I also cannot accept that simply because a jurisdiction has chosen to enact legislation like we have before us and have then failed to protect the safeguards there in the first place that somehow we are automatically going to slip into the same problem. Like Dr Broad, I have been able to put to one side the arguments about the slippery slope and trust that future parliaments, if I am not a member of them, will protect the safeguards in this bill.

I thank Ms Giddings and Mr Bacon, who took some time out of his contribution to detail the safeguards that are inherent in this bill because Ms Giddings ran out of time and was not able to do so.

There are people's concerns who have approached me about the bill and then there are my own concerns about the bill. I believe we need better palliative care. I believe we need legally enforceable advance care directives and we need better aged care, although I concede this is an area we have vastly improved. We have improved palliative care as well but I have met enough palliative care professionals now who have said to me that it is not perfect. Some palliative care professionals have said to me that 100 per cent of cases can be dealt with, but I have spoken to enough people who I trust who have worked in this space who said that as preferable as it would be, it is simply not the case.

The NDIS is a positive move towards better caring for disabled and those who cannot care for themselves. How does this bill present itself in relation to the NDIS? They are not incompatible. I believe we can provide the insurance scheme that funds the services necessary to look after disabled people and still believe in the tenets of this bill. Are we making a decision in this place that sends a signal that some lives are worth less than others? That is a decision that has weighed on my mind as well. It is an argument that has been made by people who are close to me who I trust and whose opinions I value deeply. I will deal with that.

Some members in their contributions have asked how this bill stands against our commitment to reducing suicide in Tasmania. It is a question I asked myself and I will deal with that a little further on. Another concern is, whether they are involved or not, this bill will mean medical professionals are possibly involved in this process. Again there are safeguards in the bill that make it clear that medical professionals are free to make their own decisions on their involvement or otherwise in this process and to a certain extent I have been reassured by that safeguard.

I move on to what are the positive aspects of the bill for me. One of them is that my fundamental belief as a Liberal is how do we give people the most autonomy possible to live their lives free of government restriction? I believe this bill does that; that we are able to involve people in decisions about their own end of life care rather than leaving it to doctors to make the decision. People have made contributions talking about the fact there can be no perfect legislation. We do not live in a perfect world. Far from it after looking at the scenes in Manchester over the past two days. As legislators, as much as it would be great if we could have a perfect piece of legislation, it could not necessarily happen. Sometimes decisions have to be made and consequences have to be weighed. Modern medicine means we can now live longer. We can live longer because of the medication and advancements in treatment. Do we as a parliament have an obligation to deal with end of life care in today's medical environment? I think we do.

At the AMA briefing yesterday one of the doctors said that most people who support euthanasia do not choose that option at the end of their life. He presented it as though it was an argument against supporting it - if somebody supported euthanasia all through their life and then they got to the end of their life and chose not to. It reassured me that they did that. What that said was that they were looking for choice. They were not looking for the definitive action; they were looking for the choice and the autonomy. They were looking for the option and the comfort that that gave them as they progressed through palliative care. They were palliated and did not get to a point where their pain was not manageable. They were one of the lucky ones, so to speak. When we are talking about death it is hard to talk about 'lucky ones'. That reassured me more than put me off the legislation.

As hard as it has been, there have been horror stories that have been reported to me about people who take matters into their own hands. When I was assessing how this bill stands against our commitment to reducing suicide in Tasmania, I came to the conclusion that our end of life care situation as it stands is causing suicide. We have people taking their lives before it is necessary out of fear - fear they going to lose control, fear they are going to lose their autonomy, fear there is not an option, a last resort, at the end of the line for them. They take the drastic case of driving to the middle of nowhere with a shotgun or hanging themselves in a basement. The horror stories that have been presented to me have been hard to listen to but incredibly compelling.

Palliative care is not always the answer. I have heard enough stories from people who I respect to believe this. In probably 95 per cent of cases people have indicated - even people who agree with this bill - that people can be palliated. This bill is for the 5 per cent of people who perhaps at the end of their life would like to make that choice.

Discussing this bill is a conversation we need to have. Dying is a part of life and we need to deal with it. The one thing we all have in common when we walk away from this place tonight is that we are all going to die. We are all going to have to deal with this conversation at some stage with our family, our loved ones and our friends.

I believe the safeguards in the bill are satisfactory. Yesterday at the AMA briefing one of the doctors talked about double effect and the fact they wanted legislation that protected double effect. What he said to me was, 'As long as my intent is to relieve pain, if it hastens death then that is okay'. To me that means the doctor is making the decision. What I would like, and what the proponents of this bill would like is for the onus to be placed back in the hands of the individual to make that decision, rather than get to the end of life and have the doctor make the decision. For the people who claim two doctors could be influenced to sign a piece of paper to end somebody's life under this bill, I would say if all a doctor has to do at the moment and in this present legislation is lie about their intent, then how are we any better off than the situation we have now? It is as easy, if not easier, for a doctor to lie about what their intent was in administering pain medication as it is to put their signature on a piece of paper to say this person is mentally competent and able to make a decision about their end of life care.

I end up in the situation where I am standing here today talking about this bill. I thank both proponents for bringing this bill forward. I also respect everybody's contribution, whether I agree with it or not. A sign of your respect for somebody is whether you can sit and listen to an argument from them you do not agree with. I have been able to sit here in this place today and listen to everybody's contribution. I do not need any more reassurance to vote for this bill. I will be supporting this bill but if the will of the parliament is for this bill to go to a committee or an inquiry, I will not stand in the way of that either.

Just as it is not up to me to decide what quality of life is to a person who has reached the end of their life, it is not up to me to decide what reassurance, protections or safeguards other people in this place feel are necessary for the passing of this bill. If the will of the parliament is to move to another committee of inquiry, I will support that, but I also want to make it clear that that committee process

is not necessary for me to support the bill. If the move to a committee fails, I will be supporting this bill.

[7.57 p.m.]

Mr BROOKS (Braddon) - Mr Deputy Speaker, we debated this bill in October 2013. It was a very hard thing to debate back then and it does not get any easier. It is hard not only trying to understand the challenges people face when their health is so bad they would rather end their life, but trying to put yourself in their shoes. I mentioned in my previous speech that I met with a couple in the parliamentary library four years ago. These people were professional, intelligent, smart, capable people and they were explaining to me their illnesses and conditions and the fact that when they get to a certain stage in life they want the choice to end their life.

One of the hardest things I have had to do is look these people in the eye and tell them I would not be supporting the bill. I had an email from Mr Harris recently, wanting to have another discussion. In my response to him I said one of the hardest things I have ever had to do was look him in the eye and tell him I was not going to support the bill and knowing the impact that has on his life. I did not enjoy it and I still do not enjoy it. I met again with Mr Harris today and I could see he has deteriorated. I could see he is very passionate about this legislation and the impact it can have on the rest of his life, which you could say is shortening every day. This gentleman has a deteriorating condition and he does not know how much time he has.

One of the challenges was going through the concerns I had with the legislation and the concerns that he had. It has been raised by other members who have spoken before me; they are struggling to understand why someone can support the principle of this and not the legislation itself. I still support the principle of someone who is in a terminal position in their life and their health that they will die. Rather than face the fear and face the pain of that, and losing their dignity, they would rather end it. That is what I believe is the principle of the legislation.

I said it before the 2010 election and I said it before the 2014 election. I said it before I voted on the 2013 legislation and I will say it again today: I support that principle. The challenge we have within this parliament and as members of the community is how to put in place the correct mechanisms and protections that allows for that choice but protects people from coercion, pressure or from taking an option they might not want to take. It is something that this parliament, if the legislation was passed, would provide that opportunity. It becomes a more challenging decision and a lot more complicated.

We have seen from the correspondence, and I know that we have all received much of it, there is a complete separation of arguments for many of these issues. There are different views, whilst understanding the principle, but different views in how something like this can and should operate: if it has worked well elsewhere; if it is working well; if there is effective bracket creep or creep in the legislation in other jurisdictions; if, medically, this is the right option and whether this law is going to stand up.

I have been criticised often enough in this place for not listening to the Law Society on certain legislation and they have been fairly forward in some of their arguments and concerns.

Ms Giddings - Not this bill. They have said nothing about this bill. Nothing.

Mr BROOKS - I have had direct correspondence from the ex-President of the Law Society, who did say they were not speaking as the Law Society.

Ms O'Connor - Don't pretend it is the Law Society's position.

Mr BROOKS - I did not interrupt you speaking, so I would appreciate it if you did not interrupt me.

I have had some direct correspondence from legal professionals who have raised concerns surrounding this bill. It takes me back to what other members have said and the comments I made in the previous debate in 2013 around the example this sets to our younger people. I mentioned some discussions I had with my eldest daughter who was 15 at the time. I mentioned that during the second reading debate at that time. I feel the challenge we have in this parliament and the challenges I have with this bill have not yet been addressed. They have not been addressed in this legislation. I made it as clear as possible the concerns I had with the previous legislation.

In spite of the real fear and concern of those in the community I have met with, including Mr Harris who I met with again today, I had to look him in the eye again and tell him I would not be able to support the legislation. I did not like it and I was very uncomfortable. I wished I did not have to say that because I believe we should be giving the choice to people in those positions, but we should not be doing that at the expense of the vulnerable. I support the principle but I will not be supporting the legislation.

Opposition members interjecting.

Mr DEPUTY SPEAKER - Order.

Mr BROOKS - I believe Mr Jaensch, the member for Braddon, has put up a very good alternative. You want to have the debate, let us have the debate.

Ms O'Connor - Another one. The third Tasmanian parliamentary committee.

Mr BROOKS - If, as you say, the overwhelming majority of the community supports this legislation, let us go out and talk to them and see what they say.

Ms O'Connor - You know what they'll say.

Mr BROOKS - I am not satisfied that the legislation addresses my concerns and I am not satisfied the legislation puts enough protection in place for the vulnerable and the community. Everyone here knows that will not be fixed in the committee stage.

Ms Giddings - But let's debate it, let us understand what that is.

Mr BROOKS - You will have the opportunity if the parliament determines it will refer this to a committee. I believe that should be the course of action, to put these concerns on the table and let them have a debate.

Opposition members interjecting.

Mr DEPUTY SPEAKER - Order. There should be no interjections. Mr Brooks has the call and I would appreciate it if the members opposite would respect the level of debate and allow Mr Brooks to continue uninterrupted.

Mr BROOKS - I see this as an opportunity for the parliament to continue to work with the community. I believe there are people out there who do not understand the consequences of this legislation and people who do not understand the legislation is up for debate. We need to do more to engage with the community on this issue. This is not a bill to change a traffic infringement or

anything like that. This is a very serious, consequential piece of legislation. It would be untenable, given the feedback I have received and the concerns raised with me by people in the community I respect and trust, as a member who is elected by the people to come here and represent them, to not hear them more on this issue. The best way for that to happen is to put it to a committee. Those opposite may disagree but I will not be voting for the legislation. It is not adequate. It does not cover the vulnerable. I do not believe that this bill takes into account the protection of the vulnerable enough. Based on the feedback I have had from medical experts and the legal practitioners I am engaged with, that there are some serious problems with this legislation. In fact, I think the option on the table is a pretty good one.

Let us go out and talk to the community, let us go and see what they have to say, let us engage more properly and then let us also tie that in with the palliative care outcomes that are vitally important to legislation like this. No-one in this place underestimates the concern or the problems that those people face. I seriously do not, and I understand that some may be fearful that the committee may not be able to report in time if it were for this sitting of Parliament. If I were to be re-elected at the next election, I would also support a continuation of the committee looking at this.

We need to do this. We need to have a better discussion with the community. We need to have a better strategy in going through what the concerns are, clause by clause, with those who are affected. The committee is set up specifically for that and if, at the end of the day, those concerns are addressed and those concerns are worked through and we can get legislation that addresses the fears of many, not only on this side but on all of us in this chamber, then that is a better outcome for not only the community but also those seeking this legislation to come in.

I have sat here in opposition and in government when we have put legislation through that we know might need a little bit more work. This is not the sort of legislation we should be putting through if we think it needs a bit more work. The feedback I am getting from the people I spoke to are this needs a bit more work. They have a lot of problems with it, so I might like the principle of it but at the end of the day the majority of people who have given me feedback have got problems with this legislation and the best way to address that is through the committee and I am certainly happy to support Mr Jaensch's amendment. If the committee cannot get this done in this term of parliament then I am more than happy to support it continuing in the next one if I were fortunate enough to be returned by the electors of Braddon.

Ultimately, this bill does not address my concerns, it does not address the concerns of the majority of those who have contacted me and it also can be worked on more so in consultation with the wider community. That is not a criticism of those who have done work on this legislation. I accept it is improved legislation from the previous one in 2013. However, it does not go far enough and the community should have a further say on this legislation before it is passed into law.

[8.14 p.m.]

Mr SHELTON - Madam Speaker, I rise to make my contribution to the Voluntary Assisted Dying Bill. One of the advantages of having Shelton as a surname is that it is well down the alphabet. I get to listen to the whole debate before I get up and I appreciate that fact because my local government background is that you listen to the whole debate to try to work out where things are - it is based on your experiences, plus the knowledge of the whole group and where it is coming from. I appreciate the sense of the debate to this point in time and where it has been and the convergence of views that have been expressed in the Chamber today.

Philosophically - and people go crook at me for stating this again, as you have with other people - I am not opposed to the bill. It does not surprise me that 80 per cent of people surveyed said yes, they support euthanasia. For most of my life I have supported the concept of euthanasia. Thinking about someone at the end of their life, 85-plus with an illness; what can we do for them as a society to ease

the pain or suffering that they are going through at that time? When you stand here you are not only just a member of the public commenting on the bill, you are a legislator. You have to take everything into consideration. There have been many points put today which I agree with.

It is very difficult to make these decisions. If you have one definite view then that is easy, one way or the other. When you do not have a definite view then you have to weigh everything up that is coming towards you, all the arguments and try to make a decision. The reality is we are legislators and this decision will affect people's lives. We have heard some of the stories today and I will add a few more to that in a moment. It also has some unintended consequences, which I wish to talk about.

Mr Hidding earlier on mentioned farmers and I have been a country boy farming all my life. I have probably come across from the animal and human sense, more deaths than most people in this Chamber. From an agricultural point of view that is fairly easy to understand. We still kill our own meat and I am the main butcher; my brother and I do it. When it comes to taking life, whether it be a sick animal, an animal that you are going to eat, or as it did back in the 1990s when we had to shoot a whole heap of sheep on farm because you could not sell them, I never went through that process of killing an animal and felt good about it. There is always the sense of loss. There is a sense of dying.

I do not know in the human sense how you come to grips with that. I have had a number of issues and experience of palliative care, and I will talk about my father first. He passed away 12 or 13 years ago now from cancer, went through a fairly quick process over four or five months, but the palliative care that he had was marvellous. He asked to come home and I was actually staying with my parents the night that mum said, 'You had better come in, I think he has passed away'. You go through that process and you are really close to that whole process. My dad was on morphine and as far as the palliative care goes, it was as good as it could get. I know that he went through a situation where he wished not to be with us, but at the end of the day he chose to stay there and go through that process with mum.

Unfortunately, a couple of years after that my mother had a massive stroke and was in hospital. We were called in and she was lying there and the doctors were saying it had been massive. The three children were there and you go through all the questions about the prognosis and what is going to happen. We got to the point where we basically said: no intervention, this is it, whatever will be will be. Mum still talks about it today and she said, 'Why didn't you let me die?'. 'Mum, we did not let you die, you came back to us.' Without that 10 years she would never have witnessed her 10 great-grandchildren being born or going through that process. This is not palliative care because she did not choose to die but along that path mentally she had been up and down and at any point could have said, you know, 'Aargh'. I would expect she would fit into this very easily - one word to a doctor and a letter and she would not be with us today. In a close-knit family where you are all together and making that decision from my background and wishing we could give something to a person in position, I cannot see there being too many problems. The philosophical question then comes in that where and how do you draw the line?

I will talk about two of my best mates at high school. We went through high school together and one is particularly close through family connections. The first one, at 17 or so, was diagnosed with cancer, a lump and at first they thought it was hydatids because there was a bit of that around at the time. He went through that process and was diagnosed with cancer - no treatment, go away to die, basically, was the prognosis. The family never accepted that and went searching and found another doctor. He went through a process and is now talking about retiring in a year or two. There are no guarantees with this that doctors can have it perfect all the time. That is the issue with this whole process: there are no guarantees.

My other mate who was in the same class as us was a motor mechanic and went through the trade in the same years I did. He contracted cancer 20 years ago and went through the whole treatment and has been in and out of the clinic for 20 years. They keep telling him, 'That's it, you're gone', and he

keeps fighting it and has had blood transfusions and bone marrow transfusions and different things. He has a family he has been able to grow up with because of that. The initial prognosis was only a few months. I am saying while there is life there is hope and the point is, these were younger people.

I have this philosophical point of view that at the end of your life I do not have any problem with it, but it has a cascading effect back through the life cycle, back through the years to where you draw the line.

I will raise another scenario. Imagine as a parent that your 17-year-old child has contracted a form of cancer and you have been to the specialists and he or she has been through chemo and radiation and the prognosis is not good but they are still going forward. At 18, frustrated and slightly depressed, there is a choice for that 18-year-old, under this legislation not to tell the parents, to go to the doctor and ask or write him a letter, go through that process, and the parents would not know their son or daughter has basically committed suicide. There are parts of the legislation that prevents the doctor from telling the parents. Or it could your partner, your wife, who goes through that process, goes off to the doctor and finds they have terminal cancer. This legislation has some significant issues.

Ms Dawkins - Are you saying that if your wife had cancer that someone would have to tell you? It is entirely up to her who she tells. You don't control who she talks to.

Madam SPEAKER - Order.

Mr SHELTON - But as a parent of an 18-year-old, and you have just been through 12 months of horrific conditions with them, you want to best for your son or daughter and you believe that while there is life there is hope. Yes, they are slightly depressed by the whole situation, but as I have indicated through my two examples of my two mates there could be 20 or 30 years or in fact a full lifetime in front of them, but this legislation says that they are allowed because of the autonomy to go and do that under their own free will. I get the argument that it is their right. If it is an 85-year-old I agree with you. I could put up with that but I cannot put up with the ability of a young person to go and commit suicide.

Ms Giddings - They'd do it anyway.

Madam SPEAKER - Order.

Mr SHELTON - You say they would do it anyway.

Members interjecting.

Madam SPEAKER - Order. Members will respect a member's right to have a view.

Mr SHELTON - If I could just clarify this. I was a motor mechanic teacher who taught for over 23 years at TAFE mainly dealing with young males between 15 and 18 years. Through my training and interaction with them you were their mate, you were part of them and you could tell there were always issues. Of course the TAFE college has a psychologist you can refer people to and in the group I have seen a number of times where young males would come in depressed or down. You would talk to them and they were three or so years into their apprenticeship, they were on very poor money, their mates were out running around the countryside and they were depressed. They get down at about 19, 20 in their set of circumstances and as a young person time goes so slow and they cannot see a way out of it so they become depressed. I am not relating that to this but I can understand that if a young person had a medical condition I can see how they would be depressed over their situation and could end up going to the doctor and taking their own life.

I would like to find a way to assist that older group but keep the reality of not having the younger side of it, but equity tells me it is a dilemma within me. I would like to do this but on an equitable basis how can you when you do not want to have these people over here affected either? It is a dilemma for everybody and it is not a simple process. I agree with the philosophy of the whole thing and have done for most of my life until I came into this place and am now a legislator who has to deal with these issues.

In the legislation if parents found out that their 19-year-old son or daughter had been to the doctor they could not go to that doctor and ask him to change it because they would be fined \$200 or thrown into jail for five years for approaching the doctor to change that. This legislation, as has been mentioned by some, is not about changing the speed limits so you get fined an extra \$10 or something or more often. This is about life and death and unless I can be convinced that there are no unintended consequences, there are no issues, I could not vote for it.

There is a question of whether it goes to committee or not, and I have not made my mind up about how I am going to vote on that one. I cannot vote for this bill. Whether it goes to a larger committee that has the powers, as the amendment suggests, to do a lot of things because I feel the community needs to be completely satisfied that this Parliament understands all the issues.

The mental fragility of younger people, the 18, 20 and 22 year-olds, is an issue for me and I would like to know is if society changes to a point where it allows our older generation to commit suicide basically, then what does that do to the thought processes of our younger generation?

Ms Giddings - Well, let us go into committee and discuss it because we have no right of reply so we cannot talk to you on the end of a second reading speech.

Madam SPEAKER - Order.

Mr SHELTON - That is what I want to know. This bill does not go there and I cannot vote for it because it has unintended consequences.

Ms Giddings - Do not vote for it on the third reading.

Madam SPEAKER - Order. I will not tolerate members yelling at other members during a debate.

Mr SHELTON - I have mentioned the pressures on the doctors under this bill is unbelievable. I do not know how else you would go about it but the pressure that is on the doctor is unbelievable.

Ms O'Connor - They are doing it every day.

Madam SPEAKER - Order.

Mr SHELTON - They are making decisions every day. These are life and death situations. They are not saying, you have the flu or you could have this or you could have that, take this pill and we will work out next week whether you are right or not. You are dead or alive and doctors have made incorrect diagnoses in the past and it will happen again. Under this legislation, I am sure there would be some people who would have survived the issues, but because of the situation would take this process and would not have survived.

The doctors, it is all right, they will not make any mistakes. I remind the House that doctors every day write medical certificates so that people can have days off and these individuals have real illnesses. Every person we know of who has had a medical certificate so they could have a day off, we know that they have always been crook. We know that the doctors have not had the wool pulled

over their eyes and so there is a process in this where the doctor has to make an assessment of an 18-year-old or a 20-year-old. If a 20-year-old really wanted to convince the doctor about some issues then I am sure they could and therefore they would not be alive.

I do not know whether I should go down this track - if anybody has been in the same situation as I have where you have had a very close relation, younger, 19 or 20, that has had a break-up, is in a very poor mental state and has rushed away in a car driving around indicating that life was not worth living. You have jumped in the car to try to find them and not known if you did find them where they would be and what state they would be in. Young people can get very upset, very depressed and they can make wrong decisions very easily. In this case, in this bill, that can be done in isolation by only talking to the doctor. I would like to guarantee that nothing adverse would happen but this bill allows it to and so I cannot support the bill in its current form.

The House divided.

AYES 7

Mr Brooks
Ms Courtney
Mr Gutwein
Mr Hodgman
Mr Jaensch (Teller)
Mr Shelton
Mr Street

NOES 17

Mr Bacon (Teller)
Mr Barnett
Dr Broad
Ms Dawkins
Mr Ferguson
Ms Giddings
Mr Groom
Mr Hidding
Mr Llewellyn
Ms O'Byrne
Ms O'Connor
Ms Ogilvie
Mrs Petrusma
Mr Rockliff
Mrs Rylah
Ms White
Ms Woodruff

Amendment negatived.

Question - That the bill be read the second time -

The House divided -

AYES 8

Mr Bacon (Teller)
Ms Dawkins
Ms Giddings
Ms O'Byrne
Ms O'Connor
Mr Street
Ms White
Ms Woodruff

NOES 16

Mr Barnett
Dr Broad
Mr Brooks
Ms Courtney
Mr Ferguson
Mr Groom
Mr Gutwein
Mr Hidding
Mr Hodgman
Mr Jaensch (Teller)
Mr Llewellyn
Ms Ogilvie
Mrs Petrusma
Mr Rockliff
Mrs Rylah
Mr Shelton

Second reading negatived.

The House adjourned at 8.42 p.m.