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END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING BILL 2020 (No. 30)

Second Reading

[3.02 p.m.]
Mr GAFFNEY (Mersey) **-** Mr President, I congratulate the member for Rosevears on her wonderful speech, and I wish her all the best in being elected to this place representing your community. I also congratulate the member for Huon who spoke so eloquently at the last

sitting. I also welcome back our colleague, the member for Pembroke; I am sure you are going to balance being a mother and your professional life very well.

Mr President, I move -

> That the bill be read the second time.

Honourable members, the bill before you today seeks to provide for, and regulate access to, voluntary assisted dying, to establish the Commissioner of Voluntary Dying, and for related purposes.

I begin by explaining how this legislation came to be. As members may be aware, the issue has had a long history in this state. Two inquiries have been held, and three bills pertaining to voluntary assisted dying have been tabled in the other place. I thank former members, Lara Giddings, and now Senator Nick McKim, and the current leader of the Greens, Ms Cassie O'Connor, for their hard work and tenacity in constructing and presenting those bills.

Voluntary assisted dying - in fact, end-of-life choices in general - is a difficult topic for many people to discuss openly, let alone agree upon. Therefore, it was not entirely unexpected, in previous political and social climates, that the bills were not successful, despite the best intentions and efforts of their proponents.

The Greek philosopher Heraclitus said 'The only constant in life is change' - and change things have. Honourable members, it is not a difficult task for any of us to recall times - which perhaps seem like only yesterday - when political, familial and community views were very different from those we experience today.

I was born in late 1959 - a time the societal landscape seems, to younger generations at least, completely removed from current norms. To name but a few issues –

- The Vietnam War conscription policy, which caused painful divisions between families and friends and ultimately resulted in huge numbers of unsupported and marginalised veterans.

- The absence of rights for, or recognition of, Indigenous people, then still referred to in the Constitution as natives, which seems almost hard to believe in 2020.

- The first wave of feminism since the suffragettes took off, with many women foregoing the norm of life at home - keeping house and raising children, women being re-identified upon marriage from Miss Jane Jones to Mrs John Smith - and women protesting, demanding equality in the workplace, and having control over their own bodies and finances. Changes are still needed within those areas.

However, things have changed. Time has marched on. So many of the freedoms, privileges and rights we enjoy today were hard fought for and often just as fiercely resisted.

But as I found frequently on the path to tabling this bill, the things in life that really matter rarely come easily.

Voluntary assisted dying became legally accessible in Switzerland with an amendment to its criminal code in 1942. Since then other countries and jurisdictions have adopted the practice for their citizens, using a range of legislative structures. Interestingly, 50 per cent of all voluntary assisted dying legislation in the world has been passed in the last five years. As VAD has become legal in more jurisdictions, including two Australian states, our communities have become more educated and more aware. As members may have noted from their own polling, the average statistic indicates 85 per cent of people in Australia support the implementation of voluntary assisted dying legislation. As Mr Ian Wood of the Christians Supporting Choice for Voluntary Assisted Dying stated during his presentation to us on 26 August, the most recent YouGov poll of Christians in Queensland showed 79 per cent Anglican, 68 per cent Catholic and 83 per cent United Presbyterian supported voluntary assisted dying.

In late 2018, the then president of Dying with Dignity Tasmania, Margaret Sing, advised that after decades of research and lobbying and having observed the groundswell of support and ultimate success in Victoria, the organisation's executive and members were extremely keen to table a revised bill that will allow Tasmanians access to voluntary assisted dying.

We had lengthy discussions about the best manner in which to introduce the legislation, and it was decided that instead of carrying the bill - if it passed in the other place - I would in fact table a private member's bill in this Chamber. This anomaly in parliamentary process was the subject of much discussion during my community forums and communications with many groups and constituents. Some optimistically believed or assumed that if I were introducing the bill, that must have meant it had already passed in the other place. If only that were the case.

Following from my meetings with Dying with Dignity Tasmania, I travelled to five jurisdictions where VAD currently occurs - the Netherlands, Belgium, Switzerland, Canada and Oregon in the United States. I was introduced through Dying with Dignity Tasmania connections to 11 international experts, all highly regarded in their fields. They included palliative care experts, medical practitioners, university researchers and senior legal counsel; there were current and former politicians and several health practitioners who are directly involved in the assessment and administration of and eligibility for VAD - their collective knowledge of constructing and strengthening legislative frameworks, ensuring adequate safeguards and best practices, legal protections for the person and the practitioners as well as detailed anecdotal evidence of their own experiences with people utilising VAD and working closely with other end-of-life services, such as palliative care, and the families who generously and candidly shared in the interests of trying to help craft a bill absolutely tailored to suit the Tasmanian environment - absolutely tailored to suit our place.

The insights gained through these meetings and discussions have been invaluable to the process and the international experts have all remained but an email or phone call away in the months since my visits. I remain utterly grateful to each and every one of them.

Over the past year, I have had frequent meetings with the Chief Parliamentary Counsel, Ms Robyn Webb. Robyn has been an absolute powerhouse throughout the entire process. I take a moment here to thank her for her extraordinary contribution in researching, constructing and reviewing this bill from start to finish.

There have been a number of versions, as is common with all legislation, as feedback was received and expert advice taken. Suggestions for strengthening the bill were continually raised. Robyn's professionalism and experience meant that there were never any moments of panic or despair. Perhaps the odd raised eyebrow now and then, but the sense of calm resolve was ever present.

When former premier Will Hodgman gave permission for OPC to assist in this process, I could not have conceived that not only would we have the most senior and experienced drafter on the job, but that over 210 hours of work from Robyn would go into the drafting, followed by a question and answer process and preparation for clause briefings with members. I extend my thanks to the Premier and his Government for allowing continued access to OPC. The resultant bill is a testament to the skill, dedication and tenacity of Robyn Webb and the Office of Parliamentary Counsel.

I did not tell this to Robyn, but at the end of January when her first draft bill was sent to Jocelyn Downie in Nova Scotia - and Jocelyn is responsible for the Canadian bill - she was so impressed, she said to me, 'Would this lady like to come and work for us?'. I just have to say that was the high regard that Jocelyn Downie, who is one of the international experts, had for the craftsmanship of our senior officer of Parliamentary Counsel.

In January this year, which seems a very long time ago, I took the bill on the road to present a series of community forums in every local government area in the state. I found it to be an exciting month, presenting 35 forums across 29 councils. It was a whirlwind of travel: assembling and disassembling IT equipment, projectors and the screen. For the benefit of my electorate officer in the back corner, who received one or two panicked phone calls just before the forums, I would say that this aspect of the process was one of the more challenging for me.

However, it was after the forums talking to people that I had my very first taste of how many people had a story. So many of them were distressing and sad experiences ,and so many, altruistically, were desperate to support the bill. They advocated to me, 'Please get this through: we do not want anyone else to go through what our beloved brother, sister, partner, mum, dad, nan or grandpa did.'.

Indeed, when one person would stand to the side at the end of the forum to speak with me with tears in her eyes, waiting to tell me about their lost loved one, that was hard enough. But when there were two people both with tears in their eyes, I often knew that one would not be here for very much longer. That was very hard.

I suppose perhaps one of the most beautiful things about Tasmanians is that they are loyal, strong and they are community-minded. Here these people were, laying bare their most upsetting experiences, knowing this legislation could not in any way tangibly help their loved one but wanting to help those who may be faced with a similar end-of-life journey.

These face-to-face meetings and letters, phone calls and emails, as well as the hundreds of submissions we received - which members received copies of two weeks ago - have been a constant reminder to me never to lose sight of how vital, how important and how needed this legislation is.

Even though, in Tasmania, it may only involve small numbers of people and their loved ones, to those individuals contemplating or already experiencing a painful and intolerable decline, the comfort and security this bill will provide in ensuring they will find relief from their suffering at a time of their choosing cannot be understated.

Throughout the year I have sought and received input into the consultation draft of the bill by meeting with and contacting a huge number of stakeholders, groups and individuals, including the Australian Medical Association, Tasmanian branch; St Vincent's Hospital in Victoria, where I travelled to; members of the Royal Australian College of General Practitioners of Tasmania; Dying with Dignity Tasmania; the Australian Nursing and Midwifery Federation; the state president and manager of the Pharmaceutical Society of Australia, Tasmanian branch; and the project pharmacist from the PSA in Victoria.

I have met with the chairperson and board members of the Voluntary Assisted Dying Review Board in Victoria, the Australian Pain Society, Palliative Care Tasmania, the Commissioner for Children and Young People, DPAC, TasCOSS, disability advocates, doctors, nurses, Tasmanian medical students and staff and college students studying ethics and social issues. I have arranged briefings for members with representatives in support of, or opposed to, the bill - in some cases, against the very issue of voluntary assisted dying itself.

I have recognised at every opportunity the right for people to voice their opinion, whether they are for or against, and I have respected that opinion all the way through this process.

Mr President, I would like to welcome Jacqui and Natalie, who are here for this parliamentary sitting. I take this moment to mention the involvement of Nat and Jacq. It is fairly likely that most Tasmanians are now familiar with the sisters' story, their mother's heartbreaking and cruel decline, and their decision to fight for Tasmanians to have access to assisted dying in memory of their mum, and to honour what literally were her dying wishes. From what started out as a simple email explaining their story and sharing a diary entry from their mum's last days, Nat and Jacq were soon openly reliving their family's experience and appealing to Tasmanians to become involved in the debate. Through print, radio and social media, the sisters created Your Choice Tasmania - and what a success it has been. You should be very proud.

The impact these young women have had on the community and their fight for VAD legislation cannot be underestimated. They have been fearless, they have been selfless, and they have provided human faces to what may be seen as a complicated and clinical issue.

Your Choice Tasmania created a website where people could obtain more information, Facebook and Instagram pages, and produced a brochure urging Tasmanians to take a moment to consider this issue and to be involved. They made their voice heard: 120 000 pamphlets were delivered by volunteers across the state. Recently, the Your Choice Tasmania campaign was extended to include electronic signs and billboards, and posters encouraging Tasmanians to share their opinions and stories with members of parliament.

Jacq and Nat did not restrict their efforts to raising awareness in the community. They encouraged those in support to sign the paper and the e-petition, whose wording was as follows -

> The petition of the undersigned residents of Tasmania draws to the attention of the House the urgent need to legalise Voluntary Assisted Dying within Tasmania.
>
> Palliative care cannot always relieve the intolerable pain of those with a terminal diagnosis nearing the end of their life, despite the best intentions and efforts.
>
> Many terminally ill patients unnecessarily experience intolerable, prolonged pain. These people should have the right to die a peaceful death in a place and time of their choosing.
>
> Tasmanians deserve freedom of choice.
>
> Your petitioners therefore request the House to support the forthcoming End of Life choices (Voluntary Assisted Dying) Bill 2020.

On Wednesday 19 August, the largest ever e-petition was tabled in the other place. Ms Cassy O'Connor, MP supported the petition that was supported by 13 082 Tasmanians - 13 082 people took the time and made the effort to sign that petition. I can remember the excitement we all felt on reaching 5000 signatures - we were gobsmacked at 5000 - it really felt as though Tasmanians were on board at that point. To have reached 13 082 is nothing short of staggering. I extend my sincere gratitude to Nat and Jacqui Grey and your friends and family for all their efforts. I fully appreciate this fight has taken an immense toll on you and your families; I know your mum, Diane, would be so very proud of both of you and your initiative, your resolve and your consideration through this process for everybody. It has been remarkable.

I think she is looking down on you right this minute and is smiling and glowing at her daughters and her grandchild-to-be. I congratulate you both on your work and effort.

Mr President, on the subject of saying thank you, it is really a process fraught with danger at the second reading stage. I acknowledge those Tasmanians who have contacted me with their concerns and who will not or cannot support this legislation. I recognise, appreciate and respect your opinion and contribution to this valuably important community discussion.

However, so many people have given this bill their all through expert contributions and personal stories. I do not imagine any member who has read the submission document, Voluntary Assisted Dying - Tasmanian Perspective, could have done so without being affected. So many harrowing accounts of suffering, it would be impossible not to be moved by the pain and distress so many of our fellow Tasmanians have experienced. Many have volunteered with letterbox drops, distributing posters, sharing information on social media and in so many other ways.

Before I discuss the crux of the bill itself, I want to place on the record my sincere thanks to everybody - absolutely everyone who has assisted in bringing the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 to its tabling in this place on 27 August. I hope this parliament and its 40 elected representatives will give you the result you are all hoping for. The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 seeks to provide for and regulate access to voluntary assisted dying, to establish the commissioner of voluntary assisted dying and for related purposes.

For far too long terminally ill Tasmanians have been unable to legally end their suffering, I mention the word 'legally' because it is a somewhat disconcerting, perhaps uncomfortable fact, that a number of families have been devastated by the violent or lonely death of a loved one who made it clear that because they were unable to access a legal safeguarded, supported and painless process by which they might alleviate their pain, it was simply too much to bear and they took matters into their own hands.

On the 7 August 2019, the Western Australian Minister for Health spoke of the coroner's findings that indicated around 10 per cent of suicides are linked to chronic disease or terminal illness. He responded -

> These are the wrongful deaths we should be concerned about. This is where our compassion is lacking. We can do better than condemn people to suicide. There is also an unknown cost -the consequences of unsuccessful suicides. That people are left so desperate is shocking, and the distress for their families unimaginable.

Often the decisions that were made did not just impact upon the person and their loved ones but also upon our first responders - police and ambulance members, neighbours, those who chanced upon some very traumatic and confronting situations, and, in some cases, the emergency department personnel, mental health teams and allied health personnel who supported the person if the attempt was survived.

Mr Robert Cooke in his submission stated -

> I am a serving police officer with over thirty years of operational experience. Too often have I attended incidents of suicide of persons suffering terminal illnesses….
>
> At times the methods employed by people suffering are extremely traumatic and involve the use of firearms, self asphyxia and often drug overdoses. This leaves a terrible legacy for their loved ones, not only grieving for the loss but also dealing with possible lifelong trauma themselves due to the sometimes extreme and violent methodologies employed by the person suffering …

He went on to say -

> It is the greatest of certainties that all our lives must end. The right to choose the timing and most humane method of ending one’s life is an inalienable human right that none but the person themselves should have the ability to choose, free of fear of prosecution of loved ones and medical staff who may assist them.
>
> I firmly believe that this legislation is well overdue, and is capable of being enacted with the strictest of oversight to ensure it is only available to those who meet the required standards. It has been successfully passed in other jurisdictions and I see no reason for the continued denial of choice and dignity to those enduring untold suffering, pain and ultimately death.
>
> I hope this issue can be debated maturely and in a timely fashion to expedite its passage through parliament.

Honourable members will recall from reading the submissions I tabled when we last sat a number of utterly heartbreaking stories of desperate people taking desperate measures because there was not a kinder or a more compassionate option open to them.

Mr Bill Godfrey spoke of his family's experience. He said -

> I would like members to consider the case of Elizabeth Godfrey, my mother …
>
> Over the last ten years of her life she battled intractable pain, which became less and less possible to manage (she was allergic to all opioids) and increasingly destroyed her mobility.
>
> In the absence of VAD legislation, she made four attempts at suicide … At the end of 2002 she made the final two attempts. My brother had to tell her to stop the first attempt and she tried again the following night, this time successfully.
>
> This led to 2 years of prosecution and ultimate conviction of my brother for an offence against Criminal Code Sec 163 'Any person who instigates or aids another to kill himself is guilty of a crime.' The definition of 'aids' is so loose that any one of the family could have been accused …
>
> The comments made by Justice Underwood on passing sentence make it clear that he was unhappy with both the legislation and the sentence that the law required him to pass.
>
> Having been closely involved with this case, I am also aware of other cases where the sufferer and family have gone through a similar agony. It is not humane, it is not necessary and it should be changed.

Throughout this process, I have had a number of people share with me that their loved one would willingly have adopted this action, but for the fact that they were fearful of implicating a family member. Some people whose pain has been unable to be relieved by palliative care methods or medication with no other legal option available have literally chosen to suffer through the discomfort and agony because of their care, concern and love for their family members' futures. They simply did not want to take the risk. It is a fact that without voluntary assisted dying as an option for eligible people, some have contemplated the unbearable choice of two options - ending their life alone so as not to involve family or enduring the pain to the very end. What kind of choice is that?

Members would undoubtedly have been moved by some of the harrowing accounts of families' distress at being unable to relieve their loved ones' suffering. Some authors recounted feeling of helplessness, guilt, anger and shame, some decades after. Many of them felt they had let the person down because they simply were unable to answer their cries to stop the pain. In some of the stories, people said 'Just get a gun and shoot me', or 'Please, just do something to end it, I can't take it anymore.'.

What of the people who had an undignified, painful and frightening end to their lives? What of them, whose pain, embarrassment, fear and suffering was only relieved after a lingering, painful and intolerably miserable death? Leanda Stone wrote of her father's passing -

> We sat by his side, swabbed his dry mouth with moisture, tried to keep his aching body comfortable while we waited for him to die.
>
> I remember watching his malnourished body twitch, seeing him with head injuries from falling after trying to rush to the bathroom in a delirious state.
>
> The amount of times I collected and laundered his faecal covered clothes would be enough to shred any man of his right to maintain his dignity, but someone had to do it, while watching, waiting for him to die.
>
> He lasted only two days from when he refused nourishment, thank God, because I couldn’t possibly watch him suffer any longer.

Is that what we want for our terminally ill whose pain is unable to be managed or relieved by the most fervent efforts of dedicated excellent palliative care specialist doctors, nurses and support staff? I do not think so. That is not what we want. That is not what our community deserves. Honourable members, from the submissions and anecdotal evidence from medical professionals we know there have always been situations in which people were assisted to die but it remains, and always was, an unregulated, spoken-in-whispers practice whose mere existence speaks volumes about the need for this legislation.

Doctors and nurses whose loyalty to and compassion for their patients led them to provide assistance that is essentially illegal and in breach of their code of ethics, and at great risk to themselves professionally. It happens and we know it happens. As Ms Julia Greenhill wrote in her submission -

> The opposition of the AMA to the End-of-Life Choices Voluntary Assisted Dying Bill 2020 should now be considered as **resisting a call for reform from the community** …

> Indeed, many doctors already take action to relieve unbearable suffering in their patients, as they are called upon to do, even if this action shortens the lives of their patients.
>
> However, at present they are unprotected by law and could face disciplinary and criminal charges

In a recent paper titled 'Doctors and the Voluntary Assisted Dying Act 2017' - a Victorian act - by a Queensland academic, Jodhi Rutherford, a doctor, was quoted as saying -

> The slippery slope is much more of a risk where you don't have legislation because that's where, behind the scenes, things are happening and being done without any oversight, without any jurisdiction being in control of it….So, coercion, if it's happening, it could be happening now…

So, coercion, if it is happening, could be happening now.

Honourable members, let us work together in this Chamber today to implement a legal framework that can provide a safe, guarded and protected process for our medical fraternity and the admittedly few people who are in genuine and desperate need to access voluntary and assisted dying.

It is a fact that palliative care can help the majority of people in achieving a peaceful, comfortable end to their lives, but it cannot and does not work for all patients with all conditions.

I received a submission from Ms Madelin Corbin, a registered nurse, who summed this up more succinctly and genuinely than I possibly could. She wrote -

> There is a need for palliative care, very much. But for when things haven't worked. For when pain has escalated beyond the realms of being controlled by medication. When a soul is aching for losing their journey, there needs to be an option.
>
> And let me assure you, this is all VAD is. It's an option. Just because it exists does not mean people are obliged to use it …. The passing of this Bill would simply mean that Tasmanians get a choice.

Mr President, to expand for a moment on the concept of choice, there is a growing body of evidence from other jurisdictions, including Canada and Victoria, that a number of terminally ill patients who were assessed as eligible were so comforted that they had an option to access if their condition became intolerable that their mental health, their capacity to cope, and their quality of life actually improved. Some did not go on to use the VAD substance, but they had a choice.

Statistics show that usually about 33 per cent of people who are eligible do not continue - so, 33 per cent of the people who are eligible for VAD do not continue, secure in the knowledge that they have options.

Dr Nick Carr of St Kilda, who presented a briefing to us, recently wrote -

> Overwhelmingly, people have asked for the option of VAD to regain some control and choice; to not have to wait for a possibly unpleasant event to finally kill them; to not have to suffer the indignities of further losses of bodily function but to go quietly and comfortably at a time and with people of their choosing.
>
> For many people, just having the option has been an immense relief, even if they never went on to use it.

Honourable members may have read the Voluntary Assisted Dying Review Board's Report of Operations from 1 January 2017 to 30 June 2020 from Safer Care Victoria, released in late August. Interestingly, in a population of approximately 6.6 million people, of 341 applicants in Victoria during the period from 19 June to 30 June, 124 people self-administered, or were administered, a VAD substance that ended their suffering.

Tasmania has a population of about 535 000 people, approximately 8 per cent of the population of Victoria - so Victoria is 12 to 13 times our size. On the raw data, this provides a projection of the figures in Tasmania being in the region of 28 applicants, with perhaps 10 people in a calendar year progressing to actually utilising the VAD substance.

I remember when Victoria released that report, it said 124 deaths - that is, more than two a week - and they had 42 000 deaths that year in Victoria. So, less than 3 per cent of the people who died in Victoria that year accessed the VAD substance to relieve their intolerable suffering. Put simply, the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 will allow a small number of terminally ill Tasmanians who wish to make a choice about the timing and the manner of their death the legal right to access voluntary assisted dying, giving themselves - and by extension their loved ones - surety about their capacity to end their suffering when they so choose.

Dr Christiaan Barnard, who is perhaps most famous for performing the world's first successful heart transplant, wrote in his book *Good Life, Good Death* that a doctor's duty is not only to give the patient a good life, but also to give the patient a good death. He acknowledged that his views on patient autonomy had changed from 'preserve life at any cost' during the course of his training and work as a doctor and a surgeon. He described the story of a critically ill elderly patient who was found dead in his hospital bed having disconnected his respirator, leaving a note which stated -

> The real enemy is not death. The real enemy is inhumanity.

I think it is humanity, the right to personal autonomy and compassion, that is at the centre of this bill which seeks to allow eligible people who are suffering intolerably the option to access voluntary assisted dying.

I would like to touch briefly on the research of relatively modern philosophers, Beauchamp and Childress in an article by the Ethics Centre. The four principles Beauchamp and Childress identified in their book, *Principles of Biomedical Ethics,* as healthcare's 'common morality' are -

- First, respect for autonomy - they describe how -

  > in a healthcare setting, where patients are often vulnerable and surrounded by experts, it is easy for a patient's autonomous decision to be disrespected.

  The authors stated that -

  > Respecting autonomy isn't just about waiting for someone to give you the OK. It's about empowering their decision making so you're confident they're as free as possible under the circumstances.

- The next is non-maleficence - 'First do no harm'. Beauchamp and Childress suggested that the Hippocratic Oath, used in the past as a moral and ethical framework for doctors, be nuanced in practice, so that 'First do no harm' be regarded to mean 'avoiding anything which is unnecessarily or unjustifiably harmful'.

- The third principle is beneficence: do as much good as you can -

  > Beneficence refers to acts of kindness, charity and altruism … the applications of beneficence in healthcare are wide reaching … beneficence will require doctors to be compassionate, empathetic and sensitive in their 'bedside manner'

- Finally, the fourth principle identified is justice - distribute health resources fairly. The authors identified that -

  > healthcare often operates with limited resources … They observe(d) how resources are distributed will depend on which theory of justice a society subscribes to

I have had the privilege of meeting with Palliative Care Tasmania on a number of occasions because I wanted to understand what services are currently available and to discuss the concept that voluntary assisted dying is simply another end-of-life choice - unlikely to be required or accessed by many - but for those in need, a great comfort. While I have heard a number of spurious arguments pitting voluntary assisted against palliative care, after learning more about the existing options and the amazing support provided by PCT, it was generally accepted that while the number of people who will choose voluntary assisted dying is quite small in comparison with those engaged with palliative care, the two are not mutually exclusive, nor does a person's engagement with voluntary assisted dying preclude them from receiving support from palliative care providers.

Colleen Johnstone, CEO of Palliative Care Tasmania, whom members will recall from briefings, gave us the assurance that -

> Those people living with a life-limiting illness and exploring VAD will be able to continue to receive palliative care right up until their death.

In other jurisdictions, between 80 and 90 per cent of people accessing voluntary assisted dying are also supported by palliative care services. They were already being supported by those services. I believe the figures are likely to be similar in Tasmania. As an aside, the bill precludes any doctor or nurse from participating in the VAD process unless said professionals have voluntarily taken the requisite training package and have the appropriate qualifications. Furthermore, any health professional who has a conscientious objection to any form of participation in VAD would not be required to be involved. Of course, these protections also apply to professionals working in palliative care services.

It is a well-known fact that Palliative Care Tasmania's resources are oversubscribed and the group has repeatedly been required to reapply for funding by constructing a lengthy budget submission, something I appealed to the Government to address in a special interest speech this year, and I recently wrote to the Premier advocating on the organisation's behalf.

Pleasingly, an independent Australian report by Aspex Consulting, 'Experience internationally of the legalisation of assisted dying on the palliative care sector', commissioned in 2018, stated that in every other jurisdiction where voluntary assisted dying has been legalised the resultant focus on the palliative care sector has seen funding increases. Where voluntary assisted dying is part of the framework, there is increased funding from governments.

I know people in this Chamber would like to see Palliative Care Tasmania receive more and guaranteed recurrent funding through the budget Estimates process in any event. It is a wonderful organisation with providers working incredibly hard to support Tasmanian families during what must be very challenging and distressing times. If the implementation of voluntary assisted dying in Tasmania proves to be a catalyst for expanded investment in this area, this will be a welcome side effect of the legislation.

With all this in mind, I am now inclined to shine a light on the bill and spend some time examining what its provisions allow and how the process will work in an operational sense.

Members will have perused the supporting documentation and perhaps used the flowcharts provided. I hope these documents and the briefings to be provided by the Office of Parliamentary Counsel are and will be helpful.

I am advised that objectives and principle clauses are not always included in legislation because they can often be no more than a restatement of what the act already does; however, I will be tabling the following amendment to the End-of-Life Choices (Voluntary Assisted Dying) Bill -

> A. Objectives and principles
>
> (1) The objectives of this Act are -
>
> (a) to provide, to persons who are eligible to access voluntary assisted dying, an efficient and effective

process to enable them to exercise their choice to reduce their suffering by ending their lives legally; and

(b) to ensure that the process provided for the exercise of that choice protects and prevents persons from having their lives ended unwittingly or unwillingly; and

(c) to provide legal protection for registered health practitioners who choose to assist, or who choose not to assist, such persons to exercise their choice to end their lives in accordance with that process.

(2) A person exercising a power or performing a function under this Act must have regard to the following principles:

(a) every human life has equal value -

Ms Forrest - Are you foreshadowing an amendment here?

Mr GAFFNEY - The amendment will be circulated.

Ms Forrest - So this is not in the bill we are dealing with?

Mr GAFFNEY - The amendment is coming, yes.

Ms Forrest - So it is not in the bill now. It is an amendment.

Mr GAFFNEY - No.

Ms Forrest - Okay, I need to be clear on that.

Mr GAFFNEY - Okay. This is an amendment that will be circulated in response to the Premier's correspondence of last week.

(b) a person's autonomy, including autonomy in respect of end of life choices, should be respected;

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

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

(e) a therapeutic relationship between a person and the person's registered health practitioner should, wherever possible, be supported and maintained;

(f) a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding their care, treatment and end of life should be encouraged and promoted;

(g) a person should be supported in conversations with the person's registered health practitioner, family and carers and community about treatment and care preferences;

(h) a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in Tasmania and having regard to the person's culture and language;

(i) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region;

(j) there is a need to protect persons who may be subject to abuse or coercion;

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

Mr President, I will now explain the eligibility criteria in this bill.

First, the person must have attained the age of 18 years.

The person must meet the residency requirements, in that the person -

- is an Australian citizen or is a permanent resident of Australia, or has been a resident in Australia for at least three continuous years immediately before the person makes the first request, and

- the person has ordinarily been resident in Tasmania for at least 12 months immediately before the person makes the first request.

The person must be assessed as having decision-making capacity.

- Importantly, decision-making capacity is assessed at every stage of the VAD process where the eligibility criteria are determined - at first request, second request, consulting medical practitioner determination, final request and at final permission. This is a significantly important safeguard to protect the person and the health professionals involved in the voluntary assisted dying process.

According to clause 11(1) of the bill, a person has decision-making capacity when the person has the capacity to -

(a) understand the information or advice that is reasonably required in order to make the decision; and

(b) remember such information or advice to the extent necessary to make the decision; and

(c) use or evaluate the information or advice for the purposes of making the decision; and

(d) communicate the decision, and the person's opinions in relation to the decision, whether by speech, in writing, by gesture or by other means.

Decision-making capacity is something doctors assess on an everyday basis as part of their practice. The assessment process will reflect current clinical practices in Tasmania.

To quote a submission from the WA Joint Select Committee on End-of-Life Choices in 2018 -

> The Victorian Ministerial Advisory Panel felt that given the view of Royal Australian and New Zealand College of Psychiatrists and after feedback from nine months of consultation sessions across the medical community, to add a further consultation to a process that was already rigorous for a person who is dying a of an advanced, progressive, incurable disease, illness or medical condition, was not consistent with the compassionate nature of the legislation and was unnecessary unless there was a question of impaired decision making capacity

So, the PMP or the CMP cannot make the determination if they do not have enough or the correct information. Clause 11(4) was included as another safeguard for the person and the health professionals involved in the VAD process.

The person must be deemed to be acting voluntarily. Voluntariness is a core principle of this bill. In fact, the very title of the bill is a clear and finite expression of what it seeks to provide for those determined eligible - the End-of-Life Choices (Voluntary Assisted Dying) Bill. The bill in fact contains protections that ensure that acting voluntarily with regard to the VAD process is necessary for the person, for the medical professionals in their various roles and for witnesses and contact persons in case of private self-administration. However, in this eligibility criteria context, acting voluntarily pertains to the person seeking access to voluntary assisted dying.

In drafting this bill and seeking feedback from stakeholder groups, the issue of coercion was discussed repeatedly at length. It was acknowledged that many of the safeguards within the bill - that is, fines, training and mandatory reporting processes - are specifically aimed at deterring and identifying coercion and, if necessary, immediately ceasing the voluntary assisted dying process. It is also worth noting that the Victorian training package for practitioners who wish to participate in the VAD process contains a module on coercion. I anticipate that the planning for the training package here will draw on the Victorian experience and that the commissioner of voluntary assisted dying in Tasmania and experts involved will make amendments in accordance with this bill and for the Tasmanian setting.

Two very experienced Victorian doctors who actually work in that space, Dr Nick Carr and Dr Cameron McLaren, who provided briefings, stated that medical professionals deal with this issue regularly, both within and external to the voluntary assisted dying process, and doctors are very attuned to, 'weeding out' any signs of coercion. If there is a hint of suspicion, that doctors would, and have in the past, scheduled additional consultations and assessments to ensure the person's safety and genuine voluntariness.

The fifth one, the final eligibility criteria, is clause 13, 'When person is suffering intolerably in relation to a relevant medical condition'; relevant medical condition is defined in the bill as follows -

> Section 5(1)
>
> … a disease, illness, injury, or medical condition, of the person that is advanced, incurable and irreversible and is expected to cause the death of the person.
>
> Section 5(2)
>
> … a disease, illness, injury, or medical condition, of a person is incurable and irreversible and is expected to cause the death of the person if there is no reasonably available treatment that … is acceptable to the person and … can cure or reverse the disease, illness, injury or medical condition and prevent the expected death of the person from the disease, illness, injury or medical condition.

Just as a person who seeks to become involved in the voluntary assisted dying process must be deemed to be acting voluntarily, similarly our medical practitioners and registered nurses may also only be involved if their participation is voluntary. Any professional may be excluded from involvement at any stage by stating a conscientious objection.

In any case, no health professional may be involved unless they have a minimum of five years experience following registration as a doctor or registered nurse and they have voluntarily undertaken the voluntary assisted dying training course as dictated by the commissioner of voluntary assisted dying. The health professional who chooses to be involved must update their training every five years. It is also the responsibility of the commissioner to keep track of individual professionals' training requirements. Even if a health professional has undertaken the voluntary assisted dying training course, they are not under any obligation to be involved with any or all cases presented to them.

I imagine that the instances of someone undertaking the training and then wishing not be involved would be rare. As an example, if a doctor in a small town has been approached by a terminally ill patient whose family are openly opposed to the idea of voluntary assisted dying and the doctor feels uncomfortable with being involved, the doctor is not obliged to accept a request but may provide the details to the commissioner and support the person in order to find another doctor who may be comfortable in being involved.

Similarly, clause 15 of the bill states that a person may at any time, orally or in writing, inform the person's primary medical practitioner - PMP - or administering health practitioner - AHP - that they no longer wish to access voluntary assisted dying.

At the time of this statement, the process ceases and a note is made in the person's medical records, and the commissioner of voluntary assisted dying will be informed they no longer wish to access voluntary assisted dying.

It should also be noted that if the person withdraws from the process at any point, there is nothing to prevent them making another first request at a later stage, and the voluntary assisted dying process starts again.

In Tasmania, as in Western Australia, doctors are permitted to discuss the legality and potential availability of voluntary assisted dying as an option with patients. Indeed, it is required that all options regarding end-of-life care must be fully explained. This is not the case in Victoria, and it has been reported that this limitation has proven both an oversight and a hindrance to patient care and autonomy.

This is not to suggest that the practice is encouraged or advocated, merely that a doctor may advise a person of its availability - and in the same manner, a patient may ask their doctor or specialist for more information.

Honourable members have heard Dr McLaren and Dr Carr mention the shortcoming in briefings, and provided in articles that they believe it to be an issue that the Tasmanian bill has improved.

Should a person decide they wish to make a first request, the bill dictates that the person must have received the relevant facts in relation to access voluntary assisted dying before doing so. The relevant facts are to be contained in a form approved by the commissioner for voluntary assisted dying, and under clause 7 of the bill they have to provide the following -

> (a) information as to the operation of this Act;
>
> (b) information as how the person's eligibility … is to be determined;
>
> (c) information as to the functions of the Commissioner [of voluntary assisted dying] and contact details for the Commissioner;
>
> (d) information as to what assistance to die the person may receive from a PMP or an AHP;

(e) information as to where advice in relation to palliative care, or other treatment or pain relief, may be obtained.

They are the relevant facts a person must receive as determined by this bill.

As members would appreciate from the fifth point, it is a condition of proceeding to the point where a person makes a first request that they have also received detailed information as what all of their end-of-life choices may be, and where to seek further help, clarification or support.

I felt that clause 7(e) was particularly important to include in the relevant facts to ensure that any person contemplating engaging with the voluntary assisted dying process was actively encouraged by their medical practitioner to fully consider and investigate all the options - all the options - for managing their condition and potential decline before being permitted to make a first request. These are safeguards we have throughout this bill.

If the person has not received the relevant facts, the person is not to be taken to have made a request, but must be given the relevant facts by the medical practitioner. If a person who has received the relevant facts wishes to make a first request, the person may orally or in writing or in person request the medical practitioner to determine whether or not the person is eligible to access voluntary assisted dying.

At this point, the medical practitioner has 48 hours in which to decide and advise the person whether or not the request is accepted. This is not to determine eligibility. This is to say, 'Yes, I accept your request', or 'No, I do not accept your request.'. You have 48 hours to do it, but a medical practitioner who is not an authorised medical practitioner - that is, they have not completed the requisite VAD course, and they do not have the appropriate years of experience - must refuse a first request. If you are a medical practitioner and you do not want to be involved in voluntary assisted dying, you do not do the training and then you cannot be involved.

A medical practitioner may refuse to accept a request for any reason, including but not limited to a conscientious objection to voluntary assisted dying, and the person must be advised as soon as possible but within seven days that the request is refused. So, as soon as possible, but within at least seven days the person has to know because that is a fair and just thing to happen. A medical practitioner who refuses to accept a request may, but is not required to, provide reasons for accepting or refusing to accept the request.

A medical practitioner who accepts the first request becomes known as the person's primary medical practitioner - PMP - and I will refer to this now as the PMP throughout my contribution. The doctor is qualified, understands, has done the training, accepts the person's request and becomes the PMP. That person is in control of this process and, hopefully, that person will go from stage 1, first request, and, if need be, all the way through to the final request. However, it is incumbent on the PMP to advise the person of their decision to accept the request within seven days, to note on the person's medical records the PMP has accepted a first request from the person and to notify the commissioner for voluntary assisted dying a first request has been accepted.

I have been asked, as an aside, why we use the term PMP - primary medical practitioner. In Western Australia they use the term coordinating medical practitioner and consulting medical practitioner. That is two CMPs. We thought our bill made it clear that the primary medical practitioner is the person who has followed the case through. That is important for people to understand.

We can see this legislation already has detailed safeguards incorporated. Clauses 22 and 23 provide a detailed list of all of the actions that may or must be taken by the PMP, the primary medical practitioner, prior to determining the first request. The PMP is obliged to obtain all the relevant information in relation to the person's medical condition, the treatment, any other medical conditions, the prognosis, any complications that have arisen or that may arise, and information relating to reasonably available treatment that may relieve the suffering of that person. The PMP may, for the purpose of determining the first request, refer the person to another medical practitioner for examination and request the person to provide more information they believe is required. They can request medical records from another medical practitioner and/or request a psychiatrist, psychologist or registered health professional to provide information the PMP believes necessary to make a determination. They are the requirements of the PMP and would be spelt out in their training courses so they understand.

I was grateful to receive a query from another member about the involvement of specialists in the voluntary assisted dying process. As members would be aware, one of the more complicating and operational roadblocking issues experienced in Victoria, where a specialist opinion is required, is the difficulty of people involved in voluntary assisted dying being able to obtain appointments with voluntary assisted dying trained specialists.

Given the difficulty in accessing specialists in Tasmania already and the fact that general practitioners are specialists in general medicine, clause 23 was introduced to provide assurance that should a PMP require the advice of another specialist in order to prepare for making their determination, they may do so. Before they make a determination, they have to have all the relevant information regarding that condition. It should be noted, though, that the PMP is not involved in the process to make a specialist determination about the person's condition if that is not their specialisation - for example, a general practitioner would not make a very specific diagnosis or prognosis of a complicated multiple cancer case. That report would have to come from an oncologist. The PMP's role is to assess the person against the eligibility criteria for voluntary assisted dying. A determination of the first request, whether eligible or not eligible, is to be provided to the person. Copies are to be placed on the person's medical record and also given to the commissioner of voluntary assisted dying. If the PMP has determined a person's first request renders them eligible to access voluntary assisted dying, the person may make a second request to the PMP.

The process for the second request is nearest that of the first request, but the second request requires the signatures of two witnesses. The person must not make a second request to the PMP within 48 hours of the person having made a first request unless, in the opinion of the primary medical practitioner, the person is likely to die within seven days or the person is likely to cease having decision-making capacity within 48 hours.

If you go back to the first request and the person is determined eligible that person goes away, they may not come back for two months to see their PMP again. At that stage the PMP is required, once the request comes in, to reassess the person in their decision-making capacity, their voluntariness; the terminal disease would probably not have improved and they do not have to recheck their age or their permanent residency, but they still have to recheck their decision-making capacity and their vulnerability.

Two people must witness a second request and one of the witnesses must not be any of the following - a family member, a person who believes they may benefit financially, a residential care provider or employee in relation to the person, or a person who is a resident in the facility in which the person resides. Neither the person's PMP or CMP, consulting medical practitioner, may witness a second request. If the PMP has determined a second request is rendering the person eligible for voluntary assisted dying, the primary medical practitioner is to refer the person to another medical practitioner for a second opinion.

The primary medical practitioner says, 'Yes, you are eligible'; the second request comes in, it is signed by two witnesses, 'Yes, you are still eligible', and you then have to refer that to another medical practitioner and it starts again, so there is some consistency throughout the bill. A medical practitioner to whom the person is referred must advise the PMP within 48 hours whether they accept or refuse to accept the referral. The medical practitioner may refuse the referral for any reason and is not required to, but may give reasons for their decision; a medical practitioner who accepts the referral from the PMP becomes the CMP or the consulting medical practitioner. That person responds to the PMP and receives copies of all the medical reports and all the information in relation to the person.

The CMP may examine or ask questions of the person and may seek further information from the PMP in relation to the person. The consulting medical practitioner may also refer or request that the primary medical practitioner refers the person to another medical practitioner for examination or to a psychiatrist, psychologist or registered health professional to provide information which the consulting medical practitioner believes necessary to make a determination.

These are all the safeguards within this bill. A CMP who makes a determination in relation to a person must, as soon as practicable but within seven days, place a copy on the CMP's medical records in relation to the person and give to the commissioner a copy of the determination. The person's primary medical practitioner is to advise them of the determination, place a copy on the person's record and also send a copy to the commissioner so it is a double-checking thing. One from the consulting medical practitioner and one from the PMP.

In order to prevent undue pressure on doctors and misplaced optimism on the part of the person, if two CMPs determine the person is not eligible, the process ends. If one CMP determines it is not eligible, the person can have a chance to have a second consulting medical practitioner assess and determine, that if two of them say it, then the process ends.

Although this does not preclude the person from commencing the VAD process again and making a new request, the former PMP may not accept a first request for 12 months so you cannot go back to the same doctor and say - 'I want to go again' because you were found ineligible in the first place. There has to be some breathing space, except for certain unique circumstances, as explained in the bill, and it is too involved to go into in the second reading speech.

If the person's CMP has determined the person eligible to access voluntary assisted dying, the person may make a final request to the primary medical practitioner. This request, again, may not be made within 48 hours of the second request, unless the person is likely to die within seven days or to lose decision-making capacity within 48 hours, because if they lose decision-making capacity, they are not eligible to be part of the VAD.

A final request is an instrument in writing; once again it must be determined by the PMP if the person is or not eligible to access the voluntary assisted dying so. At the third request the primary medical practitioner still has to see whether it is voluntary and the person has the decision-making capacity.

All the way through this, we are putting in as many safeguards and checks and balances as possible. In some places, they say that perhaps we have too many, but we want to make sure this is right.

The determination of the final request must be provided in writing and must be made as soon as practicable, but within seven days. The person must be notified of the determination. A record is placed on the person's medical record and the commissioner is forwarded a copy.

If the person is determined eligible, the PMP must decide whether or not the PMP intends to continue as the administering health practitioner. The PMP can make a decision. AHPs may be medical practitioners or registered nurses who have at least five years of relevant experience since registration and have voluntarily completed the VAD training package.

I think the PMP would be heavily involved and invested in that person and would more than likely see the process from the start of the process all the way through to the end. In situations where something may occur in the PMP's life that they may not be here - and that something might happen - we cannot have the process just stop, because the person would then be then left in limbo and would have to start the process all again, so we have introduced the AHP. If the PMP cannot be the AHP, the commissioner of voluntary assisted dying has a list of the doctors and registered nurses who have done the training and have the experience, who can be called upon to act in that role.

The inclusion of VAD-trained registered nurses as potential administering health practitioners acknowledges the unique skill sets, precision and professionalism that our nurses may offer their fellow Tasmanians during the administration stage of the VAD process and is one of the things unique to Tasmania. Our community nurses are very highly regarded and highly skilled.

If we examine the most usual clinical path, we might find that the doctor and/or specialist examining and diagnosing the patient determines the most suitable courses of treatment and perhaps prescribed medicines. At this point, a pharmacist makes inquiries of the patient to ascertain if there are any other medical conditions or existing prescriptions as a safeguard before supplying the medication, and we heard this from Jarrod McMaugh.

In many circumstances in hospitals, aged care facilities, hospices or in our communities, it is in fact nurses who administer the prescribed substances to patients in accordance with the doctors' and the pharmacists' instructions.

In applying this existing clinical structure to the voluntary assisted dying process, the involvement of nurses - especially in a state like Tasmania where remote and regional communities rely heavily on the support of the community nurses if they do not have a permanent doctor or a choice of doctor - seems completely logical. For example, if we had a community and the doctor on that island or in that isolated community who was not supportive of voluntary assisted dying, but there was community nurse there who was - the person might be bedridden, the locum comes in and does the assessment, and 'Yes, you are eligible.'. It goes all the way through the process, but the locum says, 'Look, I can be there Thursday, but the flight is out at four o'clock on Friday so we are going to have to have the event at 10 o'clock on Friday morning because I have to catch the plane back to where I have come from'.

A nurse practitioner, a community nurse who knows the family, who understands the relationship, could say, 'Well, when do you want to have this?', 'Well, we would really like to have it Saturday afternoon; the whole family is around, and they are coming from all over the place and we can have the event and the nurse could be there when we take the substance.'. That would be really good because it is workable. It is a more realistic way of dealing with the situations we might face in Tasmania and that is why we have introduced the registered nurse.

The administering health practitioner's role in the VAD process, whether they are a registered nurse, a doctor or a specialist, is once again to assess the decision-making capacity and voluntariness before taking the required steps to administer the VAD substance.

Unlike the PMP and the CMP or the pharmacist, the AHP does not diagnose a person's relevant medical condition or eligibility, nor do they require qualifications to prescribe a substance. As the title suggests, the role is to administer under instruction and in accordance with the process as the bill dictates. Their role is as an administering health practitioner.

In a state like Tasmania, which has many regional or remote communities, nurses are often the first port of call for people. They regularly serve for long periods in an area that may not have a permanent doctor, providing familiarity and continuity of care. It is a fact that our skilled and experienced nurses are members of one of those trusted and highly regarded professions in society. Community feedback consistently reinforces this concept.

Having researched and spoken extensively with the ANMF, and doctors and specialists both here and in other jurisdictions, it seems appropriate to create a legislative framework for Tasmanian registered nurses who volunteer to undertake the training to act or participate as AHPs.

The AHP must sign a statutory declaration declaring that they have completed their training course within five years before the appointment, that they are not a member of the family of the person and that they do not know or believe that they are likely to benefit financially as a result of the death of the person.

As members would have noted from their research and indeed from the summary of the process, there are safeguards at every juncture for the person, for the family and for the health professionals who are involved. I do not believe a bill dealing with something as important as VAD can really be structured in any other way.

While the procedure must be accessible to those eligible, it cannot and should not be rushed. Corners must not be cut. Every person involved must be both protected and responsible for their role.

Clauses 64 to 75 provide great detail with respect to the request and for the issue of the voluntary assisted dying substance authorisation; the issuing of a substance prescription to a pharmacist who is appropriately trained and authorised; the destruction of a substance in certain circumstances; and supply of a voluntary assisted dying substance to the AHP by the primary medical practitioner.

I will not go into great detail for this section as most clauses are reflective of behind the scenes actions taken by the medical professionals involved. The person will have little to do with this part of the process with one exception, clause 69.

Clause 69 allows the pharmacist access to the person either in person or by way of video link in order that the pharmacist might be satisfied that the prescription relates to a substance suitable for use in relation to the person for the purposes for which it has been prescribed. The Pharmaceutical Society suggested that this consultation is vital as certain types of medical conditions - for example, a malabsorption issue in the stomach - could render the usual substances ineffective.

The bill outlines the final administrative requirements and provision of assistance to die for both the AHP and private self-administration pathways in parts 13 and 14. If an AHP is satisfied that a person is likely, on the balance of probabilities, to die within six months from a disease, illness or medical condition or where the person has a disease, illness or medical condition that is neuro-degenerative, and the AHP is satisfied that the person will be able to self-administer a VAD substance, the person's AHP must complete and sign a private self-administration certificate. If the person has met the criteria for, and been issued with, a private self-administration certificate, and a contact person has provided written acceptance of their appointment to the AHP and the commissioner for VAD, the administering health practitioner may supply the VAD substance to the person. In doing so, the AHP is to show the person how to self-administer the VAD substance.

Clause 91 details the duties of the contact person, including the requirement to notify the person's AHP that the person has died after privately self-administering the VAD substance and storing and returning any unused substance to the administering health practitioner. A person's AHP must notify the coroner of the death of a person. If the person has not been issued a private self-administration certificate, they will proceed with the administering health practitioner pathway.

The bill requires that an AHP makes a final determination of the decision-making capacity and voluntariness within 48 hours before the AHP receives the final permission from the person. Once again, the AHP may refer the person to another practitioner or request more information in order to make the determination. If the person is determined and is entitled to receive assistance to die, the AHP must advise the person and confirm the manner in which the VAD substance is to be administered, whether self-administered, with assistance or administered by the AHP.

A person who wishes to receive assistance to die may give to the AHP a final permission which is a signed form stating that the person has received advice from the AHP as to the manner in which the substance will be administered, a statement that the person wishes to access voluntary assisted dying and understands that as soon as practicable after permission is given, that person will be provided the substance for self-administration or be assisted to administer the VAD substance according to the wishes of the person as set out in the final permission, and a statement of intent with respect to unexpected complications.

As for the private self-administration pathway, a person's AHP must notify the coroner of the death of the person.

I will now touch briefly on the administrative functions, processes and miscellaneous matters contained with the End-of-Life Choices (Voluntary Assisted) Dying Bill.

The bill contains provisions in Part 15 for the review of decisions. Eligible applicants may apply to the commissioner of voluntary assisted dying for a review of a decision by a person's primary medical practitioner, consulting medical practitioner or administering health practitioner. The commissioner has the authority to review and make decisions upon applications in this part but may also state in the form of a special case for a decision by the Supreme Court any question of law that may arise in the hearing of, or determination of, an application. Similarly, a party to proceedings aggrieved by a determination of the commissioner may appeal to the Supreme Court against the decision, the right of appeal.

Part 17 of the bill outlines information pertaining to the appointment of the commissioner for voluntary assisted dying, the deputy commissioner and the officers of the commissioner. This section also details the functions and powers of the commissioner for voluntary assisted dying, delegation, the commissioner's role in determining voluntary assisted dying substances and in approving courses of training that will be constructed in consultation with bodies which represent medical practitioners, registered nurses, the Public Guardian and the person nominated by the Chief Civil Psychiatrist.

The commissioner for voluntary assisted dying is also responsible for keeping records of any notices, requests or other documents provided to the commissioner by primary medical practitioners, consulting medical practitioners, administering health practitioners and other persons. The commissioner must provide an annual report to the minister, who will then table the same within five sitting days after receiving the report.

> Part 17 also contains details of another safeguard in that a person who suspects any contravention to the act may notify the commissioner. The commissioner may require additional information in order to investigate and may refer the matter as she or he thinks fit. This is a critical safeguard as it allows the commissioner to involve agencies such as Tasmania Police, the Coroners Court and the Australian Health Practitioner Regulation Agency to assist with the investigation of any suspected breach of the act.

The bill contains an extensive outline of offences and penalties in clauses 122 to 130. Offences include inducements and dishonest or undue influence, false representation on being authorised to communicate on behalf of a person, not communicating faithfully on behalf of the person, falsification of records, false statements, dishonest inducement to use a VAD substance, failing to provide a notice to the commissioner, not returning unused or remaining VAD substances to the AHP contact person and offences in relation to review.

I spoke earlier of the protections for the persons involved in the voluntary assisted dying process. Part 19 of the bill provides details of the safeguards that protect persons who assist in good faith, such as the person who is present at the event, protections for medical practitioners or registered nurses or for anyone using electronic communications to discuss the person and/or the voluntary assisted dying process.

The bill concludes with the miscellaneous section in Part 20. Quite often we may regard a miscellaneous section of a document as perhaps inconsequential or an afterthought. This could not be further from the truth in this bill. One of the most important and sometimes misrepresented facts regarding VAD is the concept of VAD deaths not being suicide for the purposes of law of state. I would like to read this clause in full. It is an important distinction to make, not only for the purposes of administration issues such as insurances or wills but also for the peace of mind of any individual and their loved ones who may be struggling with long-held views - perhaps religious - on the process of voluntary assisted dying.

Clause 137 reads -

> For the purposes of the law of this State, a person who dies as the result of the administration to the person, in accordance with this Act, of a VAD substance or a substance under section 87, or the self-administration by the person, in accordance with this Act, of a VAD substance, does not die by suicide.

In accordance with this law the person does not die by suicide. The miscellaneous section also notes that if there is an inconsistency between a provision in the bill and a provision in the Poisons Act 1971 or the Misuse of Drugs Act 2001, the provision of this bill prevails. This clause with respect to conflict of acts is designed to provide clarity to those involved in the VAD process with respect to the usage of VAD substances. The bill provides authority on a number of reports and reviews which are to follow the implementation of the act.

Finally, the commissioner is, within 10 months, to provide a report to the minister on the operation of the act. Furthermore, the Governor is to appoint a panel of persons nominated by the minister to conduct the review of the operation of the act, the matters relating to the operation of the act, the scope of the act and the potential scope of the act as soon as practicable after three years.

Perhaps one of the more controversial and misreported parts of the bill pertains to the review after two years with respect to young people. I will take a moment to explain why this review is included and why I have been comfortable in weathering the inevitable sensational media storm that has ensued. It says -

> The Governor is to appoint a panel of persons nominated by the Minister to conduct a review to obtain information in relation to whether persons under the age of 18 years in other States or Territories, or other countries, are able to access processes similar to the voluntary assisted dying process under this Act.

As members will be aware, nothing in this clause indicates enthusiasm for or bias towards extending the act to include children.

Nothing in this clause means the bill will instantly mean persons under the age of 18 will be eligible. Nothing in this clause guarantees an outcome or recommendation to this independent review. Nothing in this clause compels a government to act on the information collated in such a review.

The review pertaining to young people simply provides a mechanism for an expert panel to review, in detail, legislation that exists in other jurisdictions.

Whether a panel finds legislation allowing access to voluntary assisted dying processes or similar in other jurisdictions, whether that is deemed acceptable, or required, is entirely at the panel's discretion.

The reality is that any finding or recommendation must still be adopted and actioned by the government of the day.

I am completely aware that this topic makes for an uncomfortable and somewhat confronting discussion, and it may have been easier for me - and for this bill's debate - to simply remove the review before the bill was tabled - do not put it in, it is going to be a criticism of the bill.

However, Mr President, I was not about to do that.

Earlier this year I was contacted by a Tasmanian constituent and a Victorian family who had experienced similar circumstances. They both relived the horror of their teenage daughters' illnesses, decline and death. Their beloved daughters were terminally ill and suffering intolerably. Each young lady in question, under the age of 18 - and her family - wanted her death to be peaceful and in their home environment, with loved ones by their side.

Sadly, that was not to be in either case. It was simply impossible. Those loving parents witnessed their darling girls slip away after some extremely trying and inconceivably difficult times in a hospital bed. Those conversations genuinely inspired the inclusion of this clause. I have to be honest. Discussing those families' circumstances and their angst at not being able to take their little girls home for the tranquil and gentle deaths they so wanted made me feel we should definitely put structures in place so that this issue can be thoroughly examined and considered in the future.

Research in this situation is not a bad thing. We need the knowledge of an independent review group to come back with some recommendations to the parliament. Though I met with experts in Belgium and the Netherlands, where mature minors may have access to VAD with parental permission in exceptional circumstances, I had not planned to address the issue of young people in this bill.

In other jurisdictions the idea is being explored and reviewed, but, of course, it is a difficult thing to understand or contemplate, even if, as a parent, you consider what you might do if your terminally ill child begged for your consent as their pain and suffering was unable to be relieved. I urge members to consider compassionately and objectively the importance and the genuine intent of this clause. It is not to predict or assure an outcome; it simply allows a panel to gather information and gain a deeper understanding of the issue of terminally ill young people who are suffering intolerably, and whether attaining the age of 18 years should be a permanent criterion for assessing VAD in Tasmania.

Also, at the three-year mark, the Governor will appoint a panel to conduct a review as to whether persons suffering from a disease, illness, injury or medical condition that are not expected to cause the death of the person but that is advanced, incurable and irreversible and causes the person suffering from pain that is, in the opinion of the person intolerable, to have access to the voluntary assisted dying process under this bill.

I reiterate: this is just a review - a review is in this bill to ensure those reviews take place and it comes back to the parliament of the day for those people to decide and for the government to decide whether it wants to act upon it.

I will perhaps elevate this further in the Committee stage in response to questions raised by members if need be.

Finally, the bill requires the review of the operation of the bill be undertaken at the end of each five-year period.

Members, I can fully appreciate the detailed description of the bill was perhaps a little more formal and certainly lengthier than my usual contributions in the Chamber, but with a bill of this magnitude, I felt it was necessary to provide an in-depth outline of the bill's intent, its operation and the legislative structures required to support its implementation and review.

I am really grateful for your attention today, your attendance at briefings, the research you have conducted to prepare and indeed your questions and feedback over the past few months. I look forward to your valuable contributions to the debate which I am sure will be respectful, learned and informative.

On his election the Premier, Peter Gutwein, expressed to the Tasmanian people his commitment that our Government will be a government of conviction, of compassion and, importantly, of opportunity for all.

I believe this is a worthy goal for any government and perhaps something we should all consider whether party-affiliated or independent, in opposition or in government, when we ponder our position on any piece of legislation - conviction, compassion and opportunity for all.

Once again from Jodhi Rutherford's paper in the *Journal of Law and Medicine*, a Victorian doctor was quoted as saying -

> We know that a lot of people who access voluntary assisted dying help, never actually use it. But they get enormous relief knowing it's possible.
>
> I'm talking to a bloke at the moment who has terminal cancer. And the change in his experience now that he knows this is possible, has been enormous.
>
> He is so much less anxious, so much less worried, because he knows that this is going to be a possibility.
>
> He might never use it.
>
> But there is a huge benefit to him from knowing that it's there.

The bill has been thoroughly prepared and rigorously consulted to ensure its operational functions are safe and logical for those who are eligible to choose voluntary assisted dying and that the person and health professionals are adequately protected.

The End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 provides terminally ill Tasmanians who are suffering intolerably with a humane, safeguarded and compassionate framework that supports their right to access voluntary assisted dying.

I genuinely hope it will provide Tasmanians with the reassurance and comfort they may choose in their time of need.

Mr President, members and those listening in their offices, I ask you to indulge me just for a few moments. Why are we here? This is not an existential or even a rhetorical question - it is a very personal and practical one. What I mean to ask members more specifically is: Why are you in this Chamber today? What made you put your hand up for the public scrutiny, time away from family and the pressures that come with standing for politics? If it is not your first term, what made you want to do it again? I suspect that if members were to provide answers to those questions right now, there would be a range of reasons as to why they entered politics and/or why they continue to work in this space. I imagine the one thing we all have in common is this: we all thought that we could make a real difference for those in our communities and wanted to help by being their voice in this parliament.

Perhaps we had this thought and waded into politics, immediately starting at a state level, as our two newest members, the members for Huon and Rosevears have done, or as many members here, including myself, by working in and around our communities, in local government, before we found ourselves in this esteemed Chamber.

Perhaps we did not see it in ourselves but some encouragement from someone who thought, yes, you could do a good job. You just need a little push. At some point we all made a commitment to try to make this state a better place, to work hard, to strengthen and support our communities and, above all else, to do our best for those who choose us to advocate for them. It is fairly simple if you think about it. Every time a piece of legislation comes to us we consider the impact on our communities, both immediate and long term, and we vote accordingly. That is why we are here. That is why we choose to be here.

Honourable members, I know we disagree on many things in this Chamber and sometimes outside but during this debate I hope we can all agree to put our communities' wants and needs to the forefront of our thinking.

Every now and again we find ourselves reviewing a bill, whether it is passed or not, that stands to impact literally every person in this state, now and into the future. Today is one of those days and I commend the bill to the Council.

[redacted]