

**Acknowledgement of the Inaugural Speeches  
of the Honourable Members for Huon and Rosevears**

Mr President,

I take a short moment to congratulate the Honourable Member for Rosevears on her wonderful inaugural speech and being elected to this place.

I would also like to acknowledge the earlier speech by the Honourable Member for Huon, who spoke so eloquently during our last sitting.

The first year as a Member brings many challenges and perhaps some quiet reflection along the way.

I wish them both the very best on their Parliamentary journey, and offer my genuine support and assistance at any time.

**End-of-Life Choices  
(Voluntary Assisted Dying) Bill 2020  
- Second Reading Speech -**

Mr President, I move:

That this Bill be now read a 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 Assisted Dying, and for related purposes.

I'd like to begin by explaining a little about how this piece of legislation came to be.

As Members may be aware, the issue has 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 the Hon. Lara Giddings and now-Senator Nick McKim, and the current Leader of the Greens, Ms Cassy O'Connor for their hard work and tenacity in constructing and presenting their Bills.

Voluntary Assisted Dying, in fact end of life choices in general, is a difficult topic for many people to openly discuss, 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.

Greek philosopher, Heraclitus said ***“the only constant in life is change”***.

And change, things have.

Hon. Members, it is not a difficult task for any of us to recall times (which perhaps only seem like yesterday) where the political, familial and community views were very different from those we experience today.

I was born in late 1959. Around this 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 (still referred to then in the Constitution as ‘natives’ - it seems almost hard to believe in 2020), and the first wave of feminism since the suffragettes was taking off, with many women foregoing the norm of life at home, keeping house and raising children – women, having been re-identified upon marriage from Miss Jane Jones to Mrs John Smith – women, protesting to

demand equality in the workplace, women having control over their own bodies and finances. And, Mr President, there are still changes needed within that space.

However, things have changed. Time has marched on. So many of the freedoms, privileges and rights we enjoy today were hard fought, and often just as fiercely resisted. But as I have found frequently on the path to tabling this Bill, **the things in life that really matter rarely come easily.**

Voluntary Assisted Dying (or VAD) became legally accessible in Switzerland with an amendment to the Criminal Code in 1942. Since then, other countries and jurisdictions have adopted the practice for their citizens utilising a range of legislative structures, and interestingly, 50% of all Voluntary Assisted Dying legislation has been passed in the last five years.

As VAD has become legal in more jurisdictions, including two of our Australian states, our communities have become more educated and aware... and as Hon. Members may note from their own polling....the average statistics indicated that 85% of people in Australia support the implementation of Voluntary Assisted Dying Legislation, and as Mr Ian Wood of Christians Supporting Choice for VAD stated during his presentation to Hon. Members on the 26<sup>th</sup> of August, the most recent YouGov Poll of Christians in QLD had 79% Anglican, 68% Catholic and 83% Uniting /Presbyterian in support of VAD.

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 which would 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, that I

would, in fact table a Private Member's Bill in this chamber. This anomaly in the Parliamentary process was the subject of much discussion during my Community Forums and communications with many groups and constituents - some optimistically assumed that if I were introducing the Bill, it must have meant that it had already been passed in the other place.

**If only that were the case, Mr President.**

Following on from my meetings with Dying with Dignity Tasmania, I travelled to five jurisdictions where VAD currently occurs (The Netherlands, Belgium, Switzerland, Canada and Oregon, USA), and was introduced (through Dying with Dignity Tas connections) to eleven international experts – all highly regarded in their fields. They included palliative care experts, medical practitioners, university researchers, senior legal counsel, current and former politicians and several health practitioners who are directly involved in the assessment of eligibility for and administration of VAD.

Their collective knowledge of constructing and strengthening legislative frameworks, ensuring adequate safeguards and best practices, legal protections for the person and practitioners as well as detailed anecdotal evidence of their own experiences with people utilising VAD, working closely with other end of life services such as palliative care and the families was generously and candidly shared in the interests of trying to help craft a Bill absolutely tailored to suit the Tasmanian environment.

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 of them.

Mr President, 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, and 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 legislation), as feedback was received, expert advice taken and 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...but the sense of calm resolve was ever present.

When the former Premier, the Hon. Will Hodgman gave permission for OPC to assist in the 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 would go into the drafting, followed by the QA process and preparations for Clause Briefings with Members. I extend my thanks to the Hon 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.

Mr President, 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 with 35 forums. It was a whirlwind of travel, assembling and disassembling IT equipment, projectors and a screen (and for the benefit of my Electorate Officer who received one or two panicked phone calls, I would say that this aspect of the process was one of the more challenging for me).

It was often after the forums, talking to people, that I got the very first taste of just how many people had 'a story'....so many of them of distressing and sad experiences...and so many altruistically desperate to support the Bill, as they advocated to me to *'please get this through - we don't want anyone else to go through what our beloved brother, sister, partner, mum, dad, nan, or grandpa did.'*

Indeed, Mr President, when one person would stand to the side, with tears in their eyes, waiting to tell me about their lost loved one, that was hard enough, but when two people

with tears in both of their eyes, I often knew that one would not be here for too much longer. That was very, very hard.

Perhaps one of the most beautiful things about Tasmanians is that they are loyal, strong and community-minded. Here these people were, laying bare their most upsetting experiences, knowing that this legislation could not in any way tangibly help their own loved ones, but wanting to help those who may be faced with a similar end of life journey. These face to face meetings, letters, phone calls and emails as well as the hundreds of submissions received, (of which Members received a printed copy two weeks ago) have been a constant reminder to me never to lose sight of just how vital and wanted this legislation is.

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

Throughout the year, Mr President, I have sought and received input into the consultation draft of the Bill by meeting with and contacting a huge number of stakeholder groups and individuals, including the Australian Medical Association - Tasmanian Branch, St Vincents Hospital Victoria, members of the Royal Australian College of General Practitioners - Tasmania, Dying with Dignity Tasmania, the Australian Nursing and Midwifery Federation, the State President and Manager of the Pharmaceutical Society of Australia - Tasmania and a Project Pharmacist from the PSA - Victoria, 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, DPAC, TasCOSS, Disability Advocates, Doctors, Nurses, Tasmanian Medical Students and Staff, College Students studying ethics and social issues, and arranged briefings for Members with representatives who are in support of or opposed to the Bill and in some cases for or against the very issue of Voluntary Assisted Dying itself.

Mr President, I would at this time like to welcome Jacqui and Nat Gray, who are here for this Parliamentary sitting.

I would just like to take a moment to mention the involvement of Nat and Jac. 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 VAD, in memory of their mum and to honour what literally were 'her dying wishes'.

From what started as a simple email, explaining their story and sharing a diary entry from their Mum's last days, Nat and Jac 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.

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

Your Choice Tas created a website, where people could obtain more information, Facebook and Instagram pages, and they produced a brochure urging Tasmanians to take a moment to consider the issue and make their voices heard - 120,000 were distributed - a huge job, involving many generous volunteers. Recently, the Your Choice Tas campaign was extended to include electronic signs and Billboards encouraging Tasmanians to share their opinions and stories with MPs.

But Jac and Nat did not restrict their efforts to raising awareness in the community - they encouraged those in support to sign the paper and e-petitions, 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 the life, despite the best of 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 deserved freedom of choice.*

*Your petitioners therefore request the House to support the forthcoming End-of-Life Choices (Voluntary Assisted Dying) Bill 2020.”*

Mr President, on Wednesday, the 19<sup>th</sup> of August, the largest ever e-petition was tabled in the other place. Ms Cassy O’Connor MP sponsored the petition, which was supported by 13,082 Tasmanians.

I can remember the excitement, Mr President, that we all felt on reaching 5,000 signatures - it really felt as though Tasmanians were onboard at that point - to have reached 13,082 is nothing short of staggering.

I extend my sincere gratitude to Nat and Jac Gray for all of their efforts - I fully appreciate that this fight has taken an immense toll on you and your families, and I know - truly - that your mum, Diane would be so very proud of both of your initiative, resolve and consideration for others.

I think she’d be looking down on you right this minute – smiling and glowing at her daughters and grandchild to be.

On the subject of “Thank You”, Mr President - it really is a process fraught with danger at the Second Reading stage.

I would like to acknowledge those Tasmanians who have emailed me their concerns and who will not or cannot support this legislation. I do recognise and respect your opinion, and value your input into this important discussion.

However, Mr President, there are so many people who have given this Bill their all - through expert contributions, personal stories (I do not imagine any Honourable Member who has read the submission document, *'Voluntary Assisted Dying - Tasmanian Perspectives'* could have done 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), volunteering 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 would like to place on the record my sincere thanks to **everyone, 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 2020.

I hope this Parliament, and the 40 elected representatives will give you the result you were all hoping for.

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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...and 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 7 August 2019, the Western Australian Minister for Health spoke of Coroner's findings that indicated that around 10 percent of suicides are linked to chronic disease or terminal illness. He responded:

*'These are the wrongful deaths that 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 cost of unsuccessful suicides. That people are left so desperate is shocking, the distress for their families unimaginable.'*

Mr President, often, the decisions that were made did not just impact upon their person and their loved ones... but 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....*

*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.”<sup>ii</sup>*

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

Mr Bill Godfrey spoke of his family's experience, saying:

*“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”<sup>iii</sup>*

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 have, literally - with no other legal option available - 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 their 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 one’s suffering. Some authors recounted feelings of helplessness, guilt, anger and shame, some decades after. Many of them felt that they had let the person down, because they simply weren’t able to answer their cries to stop the pain ‘*just get a gun and shoot me!*’ or to ‘*please....just do something to end it...I can’t take it anymore*’.

What of those people who had an undignified, painful and frightening end to their lives? What of them? Those 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."<sup>iv</sup>*

Is that what we want for our terminally ill whose pain is unable to be managed or relieved by the most fervent efforts of dedicate palliative care specialist doctors, nurses and support staff? I don't think so.

Honourable Members, from the Submissions and anecdotal evidence from medical professionals, we know that 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 which is essentially illegal and in breach of their codes of ethics, at great

risk to themselves, professionally.

**It happens. 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.”<sup>v</sup>*

In the recent paper, titled ‘Doctors and the Voluntary Assisted Dying Act 2017 (Vic)<sup>vi</sup>’, from 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...”*

Honourable Members, let us now work together in this Chamber today, to implement a legal framework which can provide a safeguarded and protected process for our medical fraternity, and the admittedly few people who are in genuine and desperate need of access to voluntary 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”.*<sup>vii</sup>

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 the condition became intolerable, that their mental health, capacity to cope and quality of life actually improved - some did not go on to use the VAD substance. But they had the choice.

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

Dr Nick Carr of St Kilda, 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.<sup>viii</sup>*

Honourable Members may have read the VAD Review Board 'Report of Operations January - June 2020' from Safer Care Victoria, released in late August.

Interestingly, in a population of approximately 6.6 million people<sup>ix</sup>, of 341 applicants in Victoria during the period 19 June 19 - 30 June 20, 124 people self-administered or were administered a VAD substance which ended their suffering.

Tasmania has a population of 535,500<sup>x</sup> people, or approximately 8% of the population of Victoria. 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 the actually utilising the VAD substance.

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 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 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”.***<sup>xi</sup>

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

I would like to touch briefly on the research of relatively modern philosophers, Beauchamp and Childress from an article by the Ethics Centre<sup>xii</sup> The Four Principles that Beauchamp and Childress identified in their book *“Principles of Biomedical Ethics as healthcare’s ‘common morality’* are:

Firstly,

- Respect for Autonomy
  - They described 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:

- Nonmaleficence: ‘First Do No Harm’

- Beauchamp and Childress suggested that the Hippocratic Oath, which was used in the past as a moral and ethical framework for doctors be nuanced, in practice; 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.'*

And finally, the fourth principle identified by Beachamp and Childress:

- 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*'.

Mr President, I have had the privilege of meeting with Palliative Care Tasmania on a number of occasions, as I wanted to really 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.

Whilst I have heard a number of spurious arguments pitting voluntary assisted dying against palliative care, after learning more about the existing options and the amazing support provided by PCT, it was generally accepted that while the numbers of people who will choose VAD are quite small in comparison with those who engage with palliative care, the two are not mutually exclusive nor does a person's engagement with VAD preclude them from receiving support from palliative care providers.

CEO Colleen Johnstone, who Honourable Members will recall from briefings gave 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’.*<sup>xiii</sup>

In other jurisdictions, between 80 and 90% of people accessing voluntary assisted dying are also supported by palliative care 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 undertaken 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, will not be required to be involved. Of course, these protections apply to professionals working in palliative care services as well.

It is a well-known fact that Palliative Care Tasmania’s resources are over-subscribed and that 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 earlier this year, and recently wrote to the Honourable Premier advocating on the organisation’s behalf.

Pleasingly, the independent Aspex Report - *‘Experience Internationally of The Legalisation Of Assisted Dying On The Palliative Care Sector’* of 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.<sup>xiv</sup>

I would like to see Palliative Care Tasmania receive **more and guaranteed recurrent** funding through the Budget Estimates process in any event - they are a wonderful organisation, with providers working incredibly hard in supporting Tasmanian families during what must be very challenging and distressing times - but if the implementation of VAD 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 of 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.

Honourable Members would have perused the supporting documentation, and perhaps utilised the flow charts provided, and I hope that these documents as well as the Briefing to be provided by The Office of Parliamentary Counsel are and were helpful.

I am advised that objectives and principles clauses are not regularly included in legislation, because they can often be no more than a re-statement of what the Act already does. However, I will be tabling the following amendment:

**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;*
  - (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's 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.*

I will now explain the eligibility criteria in this Bill:

- **Firstly, 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 resident in Australia for at least 3 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 (CMP) Determination, Final Request, and at Final Permission. This is a significantly important safeguard to protect the person and the health professionals involved in the VAD process.
- According to Section 11 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 be able 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 that doctors assess on an everyday basis as part of their practice. The assessment process will reflect current clinical practices in Tasmania.
- To quote from 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 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.<sup>xv</sup>*

- However, it must be reiterated that at any point, if a medical professional is unable to determine decision-making capacity, they must refer the person to a *‘medical practitioner, psychiatrist or psychologist who has the skills and training that are appropriate to make such a determination’*
- This Section, S I I - 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 2020.
    - The Bill, in fact, contains protections which 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 the witnesses and contact person (in cases of Private Self-Administration).
    - However, in this eligibility criteria context, ‘acting voluntarily’ pertains to the person seeking access to VAD.

- In drafting this Bill and seeking feedback from stakeholder groups, the issue of coercion was discussed repeatedly at length, and it was acknowledged that many of the safeguards within the Bill (fines, training and mandatory reporting processes) are specifically aimed at deterring and identifying coercion, and if necessary immediately ceasing the VAD 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 VAD, and experts involved will make amendments in accordance with this Bill and for the Tasmanian setting.
- Two very experienced Victorian doctors (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 VAD process, and that doctors are very attuned to (quote) ‘weeding out’ any signs of coercion, and if there is any 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 person is suffering intolerably in relation to a relevant medical condition.**
  - A relevant medical condition is defined in the Bill as follows:

*S5-1 ‘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’*

*S5-2 ‘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 VAD 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 health 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 of experience following registration as a doctor or registered nurse AND they have voluntarily undertaken the VAD training course, as dictated by the Commissioner of VAD.

The health professional who does choose to be involved must update their training every five years. This is also the responsibility of the Commissioner to keep track of individual professionals’ training requirements.

Even if a health professional has undertaken the VAD training course, they are not under any obligation to be involved with any or all cases which are presented to them/

I would imagine that the instances of someone undertaking the training and then wishing to not be involved would be rare, but 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 VAD - and the doctor feels uncomfortable with being involved - the doctor is not obliged to accept a request but may provide the details of the Commissioner and support the person in order to find another doctor who may be comfortable being involved.

Similarly, Section 15 of the Bill states that a person may at any time, orally or in writing, inform the person's Primary Medical Practitioner and Administering Health Practitioner 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 VAD is informed that they no longer wish to access VAD.

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

In Tasmania, as in Western Australia, doctors will be permitted to discuss the legality and potential availability of VAD as an option with patients. Indeed 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 this 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 that they wish to make a first request, the Bill dictates that the person must have received the relevant facts in relation to accessing 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 provide the following:

- \* information as to the operation of the act.
- \* information as to how the person's eligibility is to be determined.
- \* information as to the functions of the Commissioner of VAD and contact details for the Commissioner
- \* information as to what assistance to die the person may receive from a primary medical practitioner or administering health practitioner.
- \* information as to where advice in relation to palliative care, or other treatment, or other pain relief may be obtained.

As Honourable 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 to what all of their end of life choices may be, and where to seek further help, clarification or support.

I felt that this fifth point (section 7e in the bill) was particularly important to include in the relevant facts to ensure that a person contemplating engaging with the VAD process was actively encouraged by their medical practitioner to fully consider and investigate all of the options for managing their condition and potential decline may be, before being permitted to make a first request.

If the person has not received the relevant facts, the person is not 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, 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 say that eligibility is determined - but whether or not the medical practitioner wishes to take the person's request.

A medical practitioner who is not an *authorised medical practitioner* (ie has completed the requisite VAD Course and has the appropriate years of experience) must refuse a first request.

A medical practitioner may refuse to accept a request for any reason, including but not limited to a conscientious objection to VAD, and the person must be advised as soon as possible but within 7 days that the request is refused.

A medical practitioner who refuses or accepts a request MAY but is not required to, provide reasons for accepting or refusing to accept the request.

A medical practitioner who accept a first request becomes known as the person's primary medical practitioner or PMP. I introduce that acronym formally at this point, as it is commonly used within the Bill and the process from this point. The PMP is the Primary Medical Practitioner.

It is incumbent on the PMP to advise the person of their decision to accept the request, within 7 days, to note on the person's medical records that the PMP has accept a first request from the person, and to notify the Commissioner for VAD that a first request has been accepted.

So you can see, Mr President, that this legislation already has detailed safeguards incorporated.

Sections 22 and 23 provide a very detailed list of all of the actions which may or must be taken by the PMP prior to determining the first request. The PMP is obliged to obtain all of the relevant information in relation to the person's medical condition, treatment, any other medical conditions, the prognosis, any complications which have arisen or that may arise, and information relating to reasonably available treatment that may relieve the suffering of the person.

The PMP may for the purpose of determining the first request, refer the person to another medical practitioner for examination, request that the person provide more information that they believe is required, request medical records from another medical practitioner, and/or request a psychiatrist, psychologist, or registered health professional to provide information which the PMP believes necessary to make a determination.

I was grateful to receive a query from another Honourable Member about the involvement of specialists in the VAD process. As Members would be aware, one of the more complicating and operational road-blocking issues that has been experienced in Victoria (where a specialist opinion is required) is the difficulty of people involved in VAD being able to obtain appointments with VAD trained specialists.

Given the difficulty in accessing specialists in Tasmania, and the fact that General Practitioners are indeed specialists in general medicine, Section 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.

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 (eg. a GP would not make very specific diagnosis or prognosis of a complicated multiple cancer case

- this report would have come from an oncologist) - the PMP's role is to assess the person against the eligibility criteria for VAD.

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 records and also given to the Commissioner of VAD.

If the PMP has determined a person's first request renders them eligible to access VAD, the person may make a second request to the PMP. The process for the second request mirrors 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 PMP, the person is likely to die within 7 days or the person is likely to cease to have decision-making capacity within 48 hours.

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 as rendering the person eligible to access VAD, the PMP is to refer the person to another medical practitioner for a second opinion.

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 as to their decision.

A medical practitioner who accepts the referral becomes the CMP or Consulting Medical Practitioner, and receives copies of all medical reports and other 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 CMP may also refer or request that the PMP refer the person to another medical practitioner for examination, or to a psychiatrist, psychologist, or registered health professional to provide information which the CMP believes necessary to make a determination.

A CMP who makes a determination in relation to a person must, as soon as practicable but within 7 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 PMP is to advise them of the determination, place a copy on the person's records and also send a copy to the Commissioner.

In order to prevent undue pressure on doctors and misplaced optimism on the part of the person, if 2 CMPs determine the person is not eligible, the process ends - although this does not preclude the person from commencing the VAD process again by making a new request, the former PMP may not accept a first request for 12 months. (except for certain unique circumstances explained in the Bill)

If the person's CMP has determined the person eligible to access VAD, the person may make a final request to the PMP. This request may not be made within 48 hours of the second request unless the person is likely to die within 7 days or to lose decision-making capacity within 48 hours.

A final request is an instrument in writing, and once again, it must be determined by the PMP if the person is eligible or not eligible to access voluntary assisted dying.

The determination of the final request must be provided in writing and must be made as soon as practicable but within 7 days, the person must be notified of the determination, a record is placed on the person's medical records, 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 AHP - Administering Health Practitioner.

AHPs may be medical practitioners or registered nurses who have at least 5 years of relevant experience since registration and have voluntarily completed the VAD training package.

The inclusion of VAD-trained, Registered Nurses as potential Administering Health Practitioners acknowledges the unique skillsets, precision and professionalism that our nurses may offer their fellow Tasmanians during the administration stage of the VAD process.

If we are to examine the most usual clinical path, we might find that the doctor and/or specialists examine and diagnose the patient, determine the most suitable course of treatment and perhaps prescribe 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. In many circumstances in hospitals, aged care facilities, hospices or in our communities, it is in fact nurses who administer the prescribed substances to a patient, in accordance with the doctor and pharmacist's instructions.

In applying this existing clinical structure to the VAD process, the involvement of nurses (especially in a state like Tasmania, where remote and regional communities rely heavily on the support of community nurses if they do not have a permanent doctor or a choice of doctor) seems completely logical.

The AHP's role in the VAD process, **whether they are a registered nurse or a doctor or a specialist** is to once again assess decision-making capacity and voluntariness, before taking the required steps to administer the VAD substance. Unlike the PMP, 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. The role is, as the title suggests, to administer under instruction, and in accordance with the process as the Bill dictates.

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 the one area (which may not have a permanent doctor) providing familiarity and continuity of care. It is a fact that our skilled & experienced nurses are members of one of the most trusted & highly regarded professions in society – community feedback consistently reinforces this concept.

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

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

As Honourable Members would have noted from their research and indeed from this summary of the process, there are safeguards at every juncture - for the person, for the family, for the health professionals involved. And I don't believe a Bill dealing with something as important as VAD can really be structured in any other way. Whilst 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.

Sections 64 to 75, provide great detail with respect to the request and issue of a VAD substance authorisation, the issuing of a substance prescription to a pharmacist who is appropriately trained and authorised, the destruction of a substance and the supply of a VAD substance to the AHP by the PMP. 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 likely have little to do with this part of the process, with one exception:

Section 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 which is 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 (a malabsorption issue in the stomach, for example) 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 6 months from a disease, illness or medical condition; or where the person has a disease, illness of medical condition that is neurodegenerative – the person is likely, on the balance of probabilities, to die within 12 months from a disease, illness or medical condition (whether or not it is neurodegenerative)'*, 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 Commissioner for VAD, the person's AHP may supply the VAD substance to the person. In so doing, 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 AHP.

A person's AHP must notify the Coroner of the death of a person.

If a person has not been issued a Private Self-Administration Certificate, they will proceed with the Administering Health Practitioner (AHP) pathway.

The Bill requires that an AHP make a final determination of 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 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 the person will be provided the substance for self-administration, assisted to administer, or administered 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 a person.

I will now touch briefly on the administrative functions, processes and miscellaneous matters contained within the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020.

The Bill contains provisions in Part 15 for the Review of Decisions. Eligible applicants may apply to the Commissioner of VAD for a review of a decision, by a person's PMP, CMP, or AHP. 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 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 who is aggrieved by a determination of the Commissioner may appeal to the Supreme Court against the decision.

Part 17 of the Bill outlines information pertaining to the appointment of the Commissioner for VAD, the Deputy Commissioner and Officers of the Commissioner. This section

also details the functions and powers of the Commissioner for VAD, delegation, the Commissioner's role in determining VAD substances, and in approving courses of training, which will be constructed in consultation with bodies which represent medical practitioners, registered nurses, the Public Guardian and a person nominated by the Chief Civil Psychiatrist.

The Commissioner for VAD is also responsible for keeping records of any notices, requests or other documents provided to the Commissioner by PMPs, CMPs, AHPs, and other persons. The Commissioner must provide an annual report to the Minister, who will then table same within 5 sitting days after receiving the report.

Part 17 also contains details of another safeguard, in that a person who suspects any contravention of the Act may notify the Commissioner.

The Commissioner may require additional information in order to investigate, and may refer the matter as he/she thinks fit. This is a critical safeguard, as it allows the Commissioner to involve agencies such as Tasmania Police, the Coroner's 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 from parts 122-130.

Offences include:

- Inducements and dishonest or undue influence
- False representation of 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 substance to the AHP (Contact Person)
- Offences in relation to review.

Honourable Members, I spoke earlier of the protections for the persons involved in the VAD process. Part 19 of the Bill provides detail of the safeguards which protect persons who assist in good faith (such as a person who is present at the event), protections for medical practitioners or registered nurses, and for anyone using electronic communications to discuss the person and/or the VAD process.

The Bill concludes with a 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 administrative issues such as insurance or wills, but 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 VAD.

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.**”*

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 the 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.

Firstly, the Commissioner of VAD is to provide, within 10 months 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 a review of the operation of the Act, matters related to the operation of the Act, the scope of the Act, and the potential scope of the Act as soon as practicable after 3 years.

Perhaps one of the more controversial and misreported parts of the Bill pertains to the Review, after 2 years, with respect to young people. I will take a moment to explain why this Review was included and why I have been comfortable in weathering the inevitable sensational media storm which has ensued.

*“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 Honourable Members would be aware:

- Nothing in this clause indicates enthusiasm for or bias towards extending the Act to include children.
- Nothing in this clause means that the Act 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 in other jurisdictions.

Whether a panel finds legislation allowing access to VAD 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 the Bill’s debate to simply remove the review before the Bill was tabled.

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' illness, decline and death. Their beloved daughters were terminally ill and suffering intolerably – each young lady in question and her family wanted for her death to be peaceful, in her home environment and with loved ones by her side.

Sadly, that was not to be – 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 girl home for the tranquil and gentle death she so wanted, made me feel that we should definitely put structures in place so that this issue can be thoroughly examined and considered in the future.

Though I had 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 considered what you might do if your terminally ill child begged for your consent as their pain and suffering was unable to be relieved.

I would urge Members to compassionately and objectively consider the importance and **genuine intent** of this clause. It is not designed to predict or assure an outcome – it simply allows for 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 criterium for accessing VAD in the state of Tasmania.

Also, at the 3 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 is 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 – ought to have access to the voluntary assisted dying process under this Act'*.

Again, I reiterate that this review is just that – **a review**.

I will perhaps elaborate further in the Committee stage, or in response to questions raised by Honourable Members if need be.

Finally, the Bill requires that a review of the operation of the Act be undertaken at the end of each 5 year period.

Honourable Members, I can fully appreciate that the detailed description of the Bill was perhaps a little more formal and certainly more lengthy 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 which are required to support its implementation and review.

I am 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 feel sure will be respectful, learned and informative.

On his election, the Honourable Premier expressed to the Tasmanian people his commitment that:

*“Our government will be a government of conviction, of compassion and importantly, one of opportunity for all.”*

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

Conviction. Compassion. Opportunity For All.

Once again quoting from Jodhi Rutherford’s paper <sup>xvi</sup> from 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 that its operational functions are safe and logical for those are eligible to choose Voluntary Assisted Dying, and that the person and health professionals are adequately protected.

The End-of-Life Choices Bill 2020 provides terminally ill Tasmanians who are suffering intolerably with a humane, safeguarded and compassionate framework which supports their right to access Voluntary Assisted Dying. I genuinely hope that it will provide Tasmanians with the reassurance and comfort that they may choose in their time of need.

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Mr President, Honourable Members, I ask you to indulge me for a few moments.

**Why are we here?**

No, this is not an existential or even a rhetorical question. It's a very personal and practical one.

What I am meaning to ask Members is, more specifically....

**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?**

**And 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.

But I would imagine the one thing we all have in common is this....

**We all thought we could make a real difference for those in our communities, and wanted to help by being their voice in the Tasmanian Parliament.**

Perhaps we had this thought and waded into politics - immediately starting at State level, as our two newest Members (the Members for Huon and Rosevears) have done, or as

many Honourable Members here (including myself), by working in, around and with our communities in Local Government before we found ourselves in this esteemed chamber.

Perhaps we didn't see it in ourselves, but some encouragement from someone else who felt that we might just be the right person for the job - we just needed 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 chose us to advocate for them.

It's 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 chose 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 whose impact (whether passed or not) stands to impact **literally** every person in the state, now and into the future.

.....**Today is one of those days.**

I commend the Bill to the Council.

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<sup>i</sup> Parliament of Western Australia – Hansard – Wednesday, 7 August 2019 – Mr Roger Cook

<sup>ii</sup> Voluntary Assisted Dying – Tasmanian Perspectives – collated by Mike Gaffney MLC - tabled 25 August 2020

<sup>iii</sup> Ibid

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iv Ibid

v Ibid

vi Rutherford, J, *Doctors and the Voluntary Assisted Dying Act 2017 (Vic): Knowledge and General Perspectives*, Journal Title: Journal of Law and Medicine, Article Citation:27 JLM 952, Publication Year: 2020

vii Voluntary Assisted Dying – Tasmanian Perspectives – collated by Mike Gaffney MLC - tabled 25 August 2020

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