

*Bills***VOLUNTARY ASSISTED DYING BILL***Second Reading*

Adjourned debate on second reading.

(Continued from 17 March 2021.)

The Hon. R.P. WORTLEY (17:04): My contribution to the bill will be brief. I have sat through these debates on euthanasia legislation for 15 years now and hopefully, before I leave this place, I will see these laws enacted.

We all gain our views and our positions on this legislation based on our own experiences. We have all had loved ones who we have seen pass away and in various states of health and comfort. For the life of me, I really cannot understand why anyone would like to deny any person the right to choose the way they wish to end their life when they have been diagnosed with a terminal illness that will result in their death within six months.

I have discussed this issue with hundreds of people over 15 years, just to get their views. I could be at dinner, I could be anywhere, and I will just bring up the subject of euthanasia or voluntary assisted dying, just to gauge their opinion. I must say, I have almost never had somebody who has put to me that they oppose the right of a person to make their choice when they want to end their life.

My father had a stroke and was in hospital. He was always a supporter of euthanasia. One time when I was talking with him, we started talking about euthanasia. I said to him, 'What would you do if someone came in right now and said you can end your suffering? What would you do?' and he said to me, 'Look, it's a hard decision.' But he did say to me that he would like the ability to choose the time of his departure.

He did not want to suffer, he did not want to die without dignity, and fortunately he did not have to—he passed away reasonably quickly after our discussion. I always found it amazing that here was a person who supported euthanasia all his life, but made it quite clear to me that if he was able to make a choice he would hang onto life as long as he could, as long as he knew that he could make the decision when he would like to leave this planet.

As I said, I have spoken to many people regarding this issue, from a very broad range of our society, whether they are people from our multicultural communities, whether they are Christians and the like, and overwhelmingly people believe that people have the right to make a decision in regard to their voluntary assisted dying.

As a parliament, we are here to represent the people of this state. I do not see why on earth anyone would think they have the right to deny a person the right to make their own decision. It is all about choice. For those people who do not support euthanasia, their choice is that they do not have to volunteer to end their lives. But there is no way in the world that I think people should have the right to deny those people who have a very strong belief the right themselves to make that decision.

So I will be supporting this legislation. I understand there are a number of amendments. I will consider the amendments. It would be good to see us get a unanimous decision in this parliament—I doubt if that will be the case—but hopefully there is strong support for this legislation. With those few words, I will be supporting the legislation.

The Hon. F. PANGALLO (17:09): I rise to speak on the Voluntary Assisted Dying Bill 2020 as introduced by the Hon. Kyam Maher in the Legislative Council on 2 December 2020. This bill seeks to make voluntary assisted dying (VAD) legal in South Australia. We follow the jurisdictions of Victoria, Western Australia and Tasmania in legislating for voluntary assisted dying, and I understand the Queensland government have committed to introducing a bill soon. This has followed four parliamentary inquiries, including our own South Australian Joint Committee on End of Life Choices.

The bill is focused on those who are dying and provides another end-of-life option for those who are seeking a choice about how they will die. They are required to be competent when they make that choice, if given six to 12 months to live. There are 68 safeguards in the bill to ensure that it is patently clear you must be dying and meet the stringent eligibility criteria, and that these cannot be expanded upon because that is not the intention of this bill—or not yet, anyway.

I would not want this bill, if passed, to result in us becoming desensitised to, and devaluing, human life, for it to lead to the abuse of the elderly, the sick and the vulnerable. I will be supporting the second reading and I was wavering on whether to vote in favour of it. I could also offer a personal experience but I will not. However, my resolve to now register my opposition to the bill was strongly influenced by the sad circumstances behind the passing last weekend of a man we greatly admired and I was fortunate to call a friend, Vili Milisits. I intend to explain those circumstances at another time, but I believe they are relevant to this debate too.

This bill is the 17th time this type of legislation has come before this parliament. The reasons for that should be clear: euthanasia, or whatever they want to call it, is the most divisive, controversial and emotive subject to confront modern civilised society. I commend my colleague the Hon. Kyam Maher for his strong, genuine and passionate beliefs and desire to move on this. He follows a path of similar minded MPs, such as the late Bob Such, Duncan McFetridge, Stephanie Key, Anne Levy and Sandra Kanck.

I will concede that whether or not to support this legislation is the most difficult decision I have ever had to make in my own life. I have to make a decision on the lives of people I do not know, have not met and am unaware of their circumstances. Lord Michael Mustill, who was one of the UK's most liberal judges, described the debate like this:

The most intellectually demanding, the most ethically challenging and the most important for its contingent effects as well as its immediate practical impact of all the points on the line where law, medicine, belief and reason intersect.

It is true that polls are overwhelmingly in favour of VAD, and its supporters use them to advance their cause. However, some of those polls can be quite simplistic and unscientific. The brief questions put to participants often do not go to the heart of the matter. It is doubtful whether many have ever thoroughly researched the subject to get a full understanding and a proper balanced perspective of the debate, not merely giving a response just because it sounds like a good idea to put terminally ill people out of their misery. It is far more complex and complicated than that, as I have learned from my own exhaustive research.

I will also accept that I am not appropriately qualified to be making life or death calls. Not many in this place are. However, we are called upon every day to make decisions on all manner of difficult issues that affect and reflect on community expectations. To do that competently, we, as members of parliament and individuals, must research the topic thoroughly, taking note of all sides, specifically in a bill like this one.

My fear is what could eventuate if we get this step horribly wrong. There is a notable bias for the pro-euthanasia lobby in the mainstream media. Lamentably, the opposing side to this argument does not get the same column space to advocate their views. That is disappointing. There are very compelling arguments on both sides, arguments even I had not considered until doing my own research.

The last time this was debated in 2016 it failed by the one vote of the Speaker of the House of Assembly, the Hon. Michael Atkinson. He told *The Advertiser* he did so out of concern the process would be open to abuse. He was alarmed that laws in the Netherlands and Belgium had been broadened over time to cover children and people with mental illness, and I quote:

'The whole trajectory is just opening it up into a suicide charter,' he said.

This is what is referred to as the 'slippery slope', where conditions under which an individual may choose to die can take a different course and be widened. I do share some of those concerns about what has happened in those two countries, particularly in Belgium where the numbers of people choosing this path have exploded because of the type of laws they have allowed and amended.

For instance, they have allowed VAD through lethal injection for minors as young as nine and 11 and a minor aged 17. These cases and another death of a dementia patient, done without her consent, are now the subject of a criminal investigation into three medical practitioners on charges of improper euthanasia and have increased discussion about Belgium's assisted dying laws.

In the Netherlands, children 12 and older are included in the act. Also, the Netherlands, like Belgian law, allows euthanasia for people with psychiatric/mental illness to end their lives if they can prove they have unbearable and untreatable suffering. Among Belgians euthanised for mental health reasons, the most common conditions are depression, personality disorder and mild autism. A 17-year-old boy decided and was given a permit to take his own life because he had mild Asperger's syndrome and felt his life was worthless.

Alarmingly, it has been reported that the Queensland government is flagging going down this path. Tasmania has also drafted a frightening bill where there is no prohibition on providing lethal drugs to a person suffering depression or anxiety. There is a clause for a review in two years to examine extending the law to minors. Surely, it cannot be medically ethical to contemplate ending the life of a child, yet this has happened in Belgium and the Netherlands and is being proposed in Tasmania and Queensland. Will it happen here eventually?

The annual number of people who have died with assistance has multiplied almost fivefold across all age groups in the past 10 years in Belgium. Most of the 4,337 people who chose assisted dying in 2016-17 were cancer patients; 710 were mainly elderly who suffered relatively minor complaints such as blindness and incontinence; 77 chose to die because of unbearable psychiatric suffering and 119 people from the age of 18 to 29 also chose to end their life. Is this where we want to go one day? Former Prime Minister Paul Keating wrote this, and I quote:

...once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law.

Mr Keating cited a case in Belgium, where a non-terminally ill man who so regretted his sex change operation that he wanted to die was permitted to do so. Is VAD—mercy killing—going to become the ultimate solution to all life's despair?

It is interesting to note that figures from the Victorian Voluntary Assisted Dying Review Board show numbers in 2020 decreasing in terms of assessments, permit applications and those issued permits. In 2019, 224 died from taking prescribed medications, compared with 172 last year. The average age of applicants was 71; 47 per cent were female, 70 per cent had a malignancy diagnosis, while 23 per cent had a non-malignant diagnosis, many of whom had a neurodegenerative disease.

I note a submission to the state parliament's End of Life Choices committee made by South Australia Police in supporting this legislation, which cited figures suggesting that one in 10 suicides involve terminally ill people. For a six-month period last year, 10 South Australians, terminally ill, took their own lives, representing 11 per cent of the 90 suicides investigated, while seven aged between 71 to 91 took their own lives due to age.

Suicide remains a serious social issue. It is far too high, as the disturbing figures over recent years reveal. Mental health is an issue that requires far more urgent attention than it currently receives. Police were rightly concerned about the degree of pain suffered in these circumstances, not to mention the psychological impact to first responders attending these tragic events. However, we do not know the full circumstances behind those heartbreaking decisions.

A Victorian parliamentary committee report into VAD also referred to these deaths in propagating an ethical argument for its legislation discouraging suicide. It also covered abuse of the law by supposedly well-meaning doctors. If doctors are prepared to break the law when it is illegal, how are we to know this will not happen when it is legalised? Former New South Wales premier Bob Carr said in 1996 that it was not possible to codify the legal taking of human life with safeguards in legislation.

I refer to a paper by John Keown, a senior lecturer in law and ethics at the University of Cambridge and an authority on VAD. He makes very compelling arguments against the practice in his body of well-researched work, including his thought-provoking book, *Euthanasia, Ethics and Public Policy*, published by Cambridge University Press. After analysing the experience in the Netherlands, Belgium, Oregon and the laws in Victoria and Canada, he concludes that neither voluntary euthanasia nor physician assisted suicide (PAS) can be controlled if legalised. There is evidence of doctors becoming desensitised to PAS. Seventy-two per cent of doctors in the Netherlands admitted to practising euthanasia while falsifying cause of death certificates. Who is to say it does not already happen in Australia? I suspect it does.

I strongly recommend all members read Dr Keown's book, along with his paper "'Voluntary assisted dying' in Australia: the Victorian parliamentary committee's tenuous case for legalization', while considering their position. Dr Keown exposes some inadequacies in the Victorian report, comparing it to one conducted by the House of Lords Select Committee on Medical Ethics, which made a clear distinction on the reasons to retain the complete prohibition on the intentional killing of patients or helping patients kill themselves, describing it as the cornerstone of law and social relationships. He contrasts that with what he describes as the Victorian committee's 'feeble and vague formulation of that assessment', where it makes references to the slippery slope and opposition to VAD as being driven more by religious motives.

As Dr Keown points out, where the principle can be formulated in theological terms, it can also be formulated in purely philosophical terms, as the House of Lords committee recognised in expressing prohibition in terms of fundamental human equality—the cornerstone of law and social relationships. That is, the fundamental ethical and legal principles that exist: the sanctity or inviolability of human life. He states that laws which permit voluntary euthanasia/physician assisted suicide trade on the notion that there are two categories of patient, and I quote:

Those with lives 'worth living' and those who would be 'better off dead'. Such laws invite fundamentally discriminatory judgements about the worth of patients' lives. The superficially attractive argument that VE/PAS are justified by respect for patient choice fails. Laws and proposed laws for VE/PAS (like those in both Reports) do not allow them for any patient who autonomously wants them: they allow them only for some patients who want them, such as those at the 'end of life' or those 'suffering unbearably'. So, VE/PAS are not fundamentally about patient choice at all but about the judgement that the choices of some patients should be accommodated because it is thought by others in society that death would benefit them, that they would be 'better off dead'. (It is small wonder that many disability groups, who see this more clearly than many others, are leading opponents of legalisation.)

The Panel Report stated that its first guiding principle was that 'Every human life has equal value'. But to allow physicians intentionally to help patients kill themselves, and to kill them if they are physically unable to do so, is obviously inconsistent with the principle of fundamental human equality.

Dr Keown argues that laws allowing voluntary euthanasia/physician assisted suicide are not only discriminatory but arbitrary. The South Australian bill is modelled on the Victorian bill, imposing time constraints and other eligibility criteria in accessing and then granting assisted dying. The Victorian bill is in turn modelled on one in Oregon in the US. Again, this from Dr Keown in his abstract paper, and I quote:

Why PAS/VE for those who are expected to die within a year? Why not for those with conditions like multiple sclerosis or motor neurone disease (ALS) or arthritis who may face years of suffering? And why not for suffering caused by mental illness or intractable grief, or for existential suffering resulting from being old, lonely and 'tired of life'? The Report stated that the committee received 'compelling evidence' that under the current law the nature of dying for people with terminal illnesses and chronic and degenerative diseases could sometimes be harrowing. Why, then, deny relief to those with chronic and degenerative diseases who are not at the 'end of life'?

Again, the panel report read that VE/PAS allowed individuals to make choices about the end of their life. Why, then, asks Dr Keown, deny the choices of those who are not at the 'end of life' but who want to die in accordance with their 'preferences, needs and values'? Why, moreover, lethal injections only for those who are thought unable to kill themselves even with assistance? Why should other patients be denied their preference for a reliable and quick dispatch? Is it because doctors cannot be trusted with administering lethal injections?

If so, why should they be trusted with issuing lethal prescriptions? If they can be trusted with lethal injections in the case of the patient who is so incapacitated as to be thought unable to end their own life, even with assistance, why not in the case of the less vulnerable patient who is able to die with assistance but would much prefer a lethal injection, perhaps to avoid any possibility of bungling the attempt and/or of a slow lingering end?

Why, further, should the law allow a hastened death only for those who can request it? Why not for those who are suffering, perhaps even more gravely, but who are, like those with advanced dementia, unable to formulate a request? Why discriminate against them by denying them relief? Once one accepts lethal injections for the competent, one is logically committed to lethal injections for the incompetent ('non-voluntary' euthanasia or NVE). The moral case for VE rests on two arguments: respect for autonomy and the duty of beneficence.

VE is thought to be justified because we should, one, respect patients' choices for a hastened death and, two, when to do so would benefit them. Why then deny patients this benefit merely because they cannot request it? True, such patients are not autonomous, but their lack of autonomy does not negate our duty to help them. The absence of autonomy does not cancel the duty of beneficence. In what other situation do doctors withhold beneficial interventions from patients merely because the patient cannot request them? This logical slippery slope argument is unanswerable, which may well be why those who campaign for VE/PAS typically evade it.

Here is what Lord Mustill had to say on the slippery slope:

The image of the slippery slope is often called up as a warning to those who take an easy step without looking to see where the next may lead, but it also reminds us that in this area the concepts themselves are slippery. The steepness of the slope and its treacherous footing are often concealed by an emollient vocabulary. Thus the expression 'best interests' conveys an upbeat meaning at odds with its more chilling implications.

What Lord Mustill is saying is that the terminology in this debate, like 'dignified death' or 'death with dignity', can be deceptive and these words can mean vastly different things to different people.

Dr Keown says that where laws are relaxed, allowing VE/PAS like the Netherlands, evidence shows their laws have been difficult to police and to achieve control and protection. The Victorian parliamentary report claimed that instances of assisted dying are rare, even in jurisdictions where it is legal. How can 6,000 deaths by VE/PAS in the Netherlands in 2016, that is, one in 25 deaths from all causes, possibly be considered rare?

The Victorian committee visited the Netherlands. It was a short four-day trip in which they interviewed 14 individuals from political, medical and academic circles, as well as the Dutch Voluntary Euthanasia Society. One of the 14, Professor Theo Boer, was a critic of the law. Professor Boer, a former board member of the Netherlands Euthanasia Review Board, was once of

the belief that the law and its review procedure could prevent a slide. After changes in applying the law led to an explosion in numbers, he has changed his mind. Dr Boer said:

We have put in motion something that we have now discovered has more consequences than we ever imagined.

Other experts who were once euthanasia supporters and pioneers of Dutch laws hold similar cautionary views. Dr Bert Keizer says British critics are right to warn that assisted dying is a slippery slope to random killing of the defenceless. He said the type of patients whose lives are ended in the Netherlands has spread far beyond the terminally ill and now includes physically and mentally healthy old people.

Berna van Baarsen resigned from the Netherlands euthanasia review board in 2018 after saying it was wrong for incapacitated patients with dementia to be eligible for euthanasia. In the Netherlands, you do not have to be terminally ill to be granted the right to assisted dying. The suffering must be 'lasting and unbearable'. So what does that mean? Terminal illness also is not a requirement in Belgium or Quebec, Canada, where a person may receive assisted dying if they have a grievous irremediable medical condition, a serious incurable illness or disease, or—and this quite disturbs me—a disability.

The current figures from Victoria show a decline in numbers in the second year of its laws. The factors for that are unclear, but 2020 was the year of COVID. There were only two deaths from influenza in Australia in 2020, compared to the many thousands in previous years. Will this type of legislation to legalise suicide reduce the number of illegal suicides? Dr Keown says from the available evidence of jurisdictions that have legalised the VE/PAS, this view is not supported. People will have their own deeply personal views and concerns about legalising voluntary assisted dying in South Australia, and they have been vocal in making these known.

I am grateful to the people who have shared their private and often distressing experiences with me. It was important that I heard and considered the conflicting views and gave them a voice to express their feelings. Those urging me to support it included compassionate palliative care specialist Dr Roger Hunt, who recounted to me his difficult experience with a former President of the upper house, the late Hon. Gordon Bruce, as well as many of his patients.

I want to acknowledge an extremely touching letter I received from Jacqui Possingham, who lost her parents, Doug and Heather, to cancer within five years of each other, and the unbearable suffering they endured in the latter stages of their illness.

Dr John Willoughby, a neurologist who had to manage patients with chronic neurological diseases, made a case for an even longer estimated duration of death to be considered in this bill. However, I reject his assertion that failure to permit assisted dying is a failure of compassion. Compassion is the very core of this debate, no matter which side you are on. RN Susie Byrne, the convener of SA Nurses Supporting Choices in Dying, said she found that often people do not fear dying but rather the dying process. To quote Susie:

Just knowing that a VAD law exists can act as powerful palliation in itself and they pass peacefully and naturally without having to take their own lives sooner.

Dr Rosemary Jones recounted an experience as a young locum of coming across an emaciated female with ovarian cancer that her boss had failed to diagnose and attempted to cover up until he had little choice but to ply the patient with morphine so she could die. Dr Jones wrote:

Some doctors see this as ethical and appropriate management, I don't. It comes in as a poor second to assisted dying.

I was quite touched and shocked by Liz Habermann's distressing story of her 19-year-old son Rhys, who was diagnosed with Ewing's sarcoma at the age of 17, while in year 12. Rhys chose to end his own life by taking a lethal dose of illegally obtained Nembutal while his heartbroken mum recorded

his agonising death on video. It was an awful experience, with Rhys taking 12 hours to die and then having his death declared a crime. The family remains traumatised. Liz wants people to be given a legal choice rather than go down the illegal path, as her son did. She writes:

We were in it alone, and I never want another family to ever have to suffer through such a traumatising time.

I have received many equally strong arguments from those pleading that I oppose it. I do not see a need to acknowledge them here, as I have already mirrored their views in making my case in opposing the bill.

We currently trust doctors to perform procedures and provide medications that also have the potential to end lives every day, and this bill does not deal with that. At present, many people who are terminally ill are given terminal sedation, are left to starve or dehydrate or are deliberately or negligently neglected. This is not regulated, and I have some real issues with this.

I do not want us to ever become like Belgium or the Netherlands and make VAD available to anyone who is not dying or anyone below the age of 18. I do not want anyone who does not have mental competency by way of dementia or any other mental condition to access VAD. I would hope, if passed, there would be rigorous safeguards possible, and I want there to be very strict reporting.

I also do not want VAD to in any way decrease our emphasis on achieving the highest quality of palliative care. Palliative care is defined as the intention to neither hasten nor postpone death. Of course, it is unable to relieve all suffering. I note that in Victoria and Western Australia they have increased palliative care funding, and I would be looking for an assurance from this government that they intend to do the same, regardless of the success of this bill. To do so would greatly ease the burden on our overloaded health system.

I note that healthcare professionals who have a conscientious objection do not have to participate in the scheme, just as they do now, for example, in abortion procedures. This is as it should be, just as VAD doctors have to have an additional accreditation to work in the scheme.

I received a guide to VAD from Go Gentle Australia where they are critical of the AMA's opposition to VAD despite what they say is a majority of support—51.6 per cent from its own members. Majority or not, that figure falls well short of demonstrating broad medical community support for it. We can only assume 48.4 per cent do not think it has a place in their profession. That, to me, is a significant number. This place placed much credence on the AMA's stand on the recent abortion debate. Will members do the same in this instance? Perhaps the AMA's position can be defined in the way Dr Keown views the debate when he writes:

The debate is not about whether doctors and nurses should be allowed to assist people to die, which is what doctors and nurses currently do when they keep patients comfortable at the end of life with palliative treatment and care, but whether doctors should be allowed intentionally to end patients' lives by administering lethal injections or to assist them in ending their own lives by issuing prescription for lethal drugs.

To put that into perspective, it is about their ethical responsibility as medical practitioners who are trained and take the oath to save lives, not end them. Former Prime Minister Paul Keating was quite blunt in 2017 about doctors' responsibility in upholding their principles and the law as it exists. He said:

If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system...

Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied.

In 2018, the then AMA WA president, Dr Omar Khorshid, admitted doctors regularly hasten death at the very end of life—bending the rules, as Paul Keating suggests. Go Gentle says VAD laws would

eliminate this secret practice and that the lack of these laws serves to heighten the risk of mistreatment and abuse rather than it occurring with them.

Nick Xenophon, a politician I greatly admire, strongly opposed euthanasia bills when he was in the Legislative Council. His chief concern was that the state sanctioning of a law to allow euthanasia would lead to a shift from a right to die to a duty to die. I quote from the *Hansard* of the second reading contribution of the Dignity in Dying Bill on 25 July 2001:

That will lead, whatever supposed safeguards are in place, to an intolerable and emotional onus on the terminally ill to feel that if they are a 'burden' on their family they have an obligation to avail themselves of euthanasia legislation passed by this parliament.

Nick was deeply worried about the potential for the law to be abused; that society would turn their backs from efforts to assist those who are seriously ill, elderly and depressed. I agree. Legislators who ignore history are condemned to repeat it, says Dr Keown. I have my own version of that: if there is something we learn from history, it is that we learn nothing.

I will support the second reading and I look forward to the committee stage. I would also ask respectfully that in the heat of debate, members respect the opposing views. I will end this with a quote from a pioneer of palliative care, Dame Cicely Saunders, founder of St Christopher's Hospice in London, 'Suffering is only intolerable when nobody cares.'

The Hon. J.M.A. LENSINK (Minister for Human Services) (17:46): I have not prepared much of a speech, but like many honourable members I have had the opportunity to consider these matters several times over the years; in fact, three times in this place. Twice I voted against those particular amendments and once I voted in favour. In fact, it was the Hon. Mark Parnell's sponsorship of that bill on that occasion.

My views are quite similar to those of my colleague Stephen Wade, the Minister for Health and Wellbeing. I will certainly be considering his amendments quite closely. The statistics and the support for voluntary euthanasia are often quoted in our community and I understand why people are in favour of people having some control and dignity at the end of their life, particularly when they are undergoing suffering that is very hard to be a witness to but also, obviously, for the person who is going through it.

However, I do differentiate that this is often mixed up with people who are in the terminal phase of a terminal illness when basically, if I could be blunt, the morphine gets turned up, and that is supported through legislation in the Consent to Medical Treatment and Palliative Care Act 1995, section 17(1), which at the time when it was introduced by, I think, Jennifer Cashmore was quite groundbreaking.

It is often called the double effect, that if somebody is in that terminal phase of a terminal illness and they are in pain and suffering then the treating practitioners cannot be prosecuted if that has the effect of hastening their death. That is what I think most people in the community are seeking to address. Often, when I explain that to people, they are not necessarily cognisant of that.

Aside from those situations, which are already covered by legislation, the question then becomes: how do we determine what situations are not covered by existing laws but in which people obviously suffer unnecessarily and how do we manage those so that we do not have those powers abused?

I agree with my colleague the Hon. Stephen Wade as well in relation to the fact that I do have concerns that this legislation may well be being rushed to a degree and that some proper reference to a SALRI-like organisation may have assisted, so I will support the second reading, but I will be reserving my right at the final vote.

The Hon. N.J. CENTOFANTI (17:49): I rise today to indicate that I will not be supporting the bill. It is not because I do not understand the pain and suffering that some members of our community go

through at the end of their life. I have had family members who have undergone the palliative care process because of a terminal illness, and it is heart-wrenching under any circumstance to watch a family member or a friend pass away. I know—I have been there and I have felt it.

It is because I strongly believe that the lack of adequate knowledge and understanding of current legislation, such as advance care directives, as well as delivery in palliative care, must not be the reason we legislate for voluntary assisted dying. I read the report of the Joint Committee on End of Life Choices several times over the last few months since its tabling on 13 October last year. It is an excellent report that covers the divergent views, and I commend the committee, ably led by the Hon. Mr Kyam Maher, for its work.

As the report stated, like many other aspects of health care, there is a wide discrepancy between palliative care services available in the metropolitan area and those accessible in rural and remote regions. In the report, Palliative Care South Australia applauded the state government's commitment to invest in an additional \$16 million over the next four years to build capacity and ensure equitable access to palliative care services. This will aid in building 24/7 community palliative care capacity to support people at home in their final stage of life with the help of their GP and experienced palliative care community nurses.

It will also assist in integrating palliative care across the acute care setting, which will relieve pressure on the system and reduce the number of terminally ill people in hospital beds, including intensive care, and fewer emergency department presentations. Whilst this is much needed and welcomed, it is acknowledged that there is still a need to continue to invest in this sector and to increase targeted funding to ensure the increased demand for palliative care and services is met.

Further data was provided to the committee from Palliative Care Australia and the KPMG report released in May last year, which stated that an annual investment of \$365 million would see Australia's palliative care system operating efficiently. The funding would end the:

...underfunded at-home care and the token services administered too late, which resulted in people being taken in and out of hospital in their late stages in an ambulance because it is not a proper palliative care set up.

The report proposed that \$240 million would provide timely access to at-home palliative care, \$75 million would fund specialist palliative services at aged-care facilities and \$50 million would expand the end-of-life services.

The committee heard that South Australia has been a pioneer in end-of-life legislation, with the consent act being the first time in the world that palliative care had appeared in an act of parliament. It was judged to be excellent consent legislation, providing a framework for end-of-life care. The ACD Act, too, is among the most advanced in the world, promoting an advance care directive (ACD) to provide a legally binding voice for those who have lost decision-making capacity, along with the appointment of substitute decision-makers to act on the person's behalf.

Dr Chris Moy, President of the Australian Medical Association in South Australia, affirmed that the state currently has the most complete framework of legislation, with the Advance Care Directives Act and the amendments to the consent act promoting self-determination while also protecting doctors. Effectively, the current legislation offers an elegant balance in good end-of-life care by clarifying consent ages, whilst focusing on the autonomy, wishes and values of the individual.

Currently, a patient with an advance care directive can refuse treatment, even if they have lost their decision-making capacity. As a result, a doctor can be required to withdraw life-sustaining measures. Equally, doctors do not need to continue the futile treatment to a dying patient with the protection to provide adequate treatment ensuring comfort and dignity. However, the report also stated that currently clinicians are further hampered in their ability to facilitate a good death by the limited uptake of advance care directives.

Advance care directives are a legal document that allows the individual to make clear arrangements for their future health care. This includes outlining how you wish to manage decisions regarding your end of life, preferred living arrangements and other personal matters. Advance care directives allow individuals to think about their dying wishes, such as situations they may want to avoid or they would find unacceptable. They also allow individuals to communicate other end-of-life wishes, such as the intention to be an organ and tissue donor or considerations such as spiritual, religious or cultural traditions.

Advance care directives can include statements such as, 'I would prefer to have better quality of life for a shorter time', 'I want more time with my family', 'If I am dying, I do not want to be transferred to a hospital unless my comfort and dignity cannot be maintained in my home or place of care' and 'I want time to say goodbye to my family if possible. Please try to keep me alive so my family can see me before I die.' Advance care directives can be and should be utilised by the community to outline not just their dying wishes but also their position if tragic circumstances unfortunately substantiate. Advance care directives should not just be for the elderly; they should be for all of us.

In fact, prior to my role here in parliament I had no idea about advance care directives. I have begun drafting my advance care directive as I want to ensure that my wishes are known to my loved ones in case, God forbid, something horrific were to happen to me. I recommend all South Australians visit the government website on advance care directives, as it is informative and contains resources such as templates aimed to assist individuals to draft their own directive.

There is a need for greater education amongst clinicians, care workers and emergency services about the operation of advance care directives and their importance to the dignity and wellbeing of those who have chosen to prepare them. In doing so, we must also ensure that palliative care has a focus on affirming life, promoting quality of life, treating the patient and supporting the family.

There were many who appealed to the committee to oppose any legislative change to enact voluntary assisted dying in South Australia, whether in terms of the Victorian act or otherwise. As to the appropriateness of the same bill that passed in the Victorian parliament being enacted in South Australia, whilst there are a few in support, many advocates for voluntary assisted dying expressed their concern and disappointment with the Victorian model because of the high level of restrictions and safeguards.

I think this highlights the risk we face in the future in maintaining these safeguards and ensuring these protections are not eroded. I personally am grateful for these safeguards. If this bill does pass this chamber and the other place, it gives me some level of comfort that it is a direct translation of the Victorian model, which has been described as the safest and most conservative scheme in the world by the Victorian Premier, with some 68 safeguards in place. I just hope it stays that way.

Sitting suspended from 17:58 to 19:45.

The Hon. J.S. LEE (19:46): I rise to speak on the Voluntary Assisted Dying Bill 2020. I understand that this bill is perhaps the 17th attempt that various members have brought to the South Australian parliament to allow voluntary assisted dying to occur for people facing certain circumstances. I thank the Hon. Kyam Maher for introducing this bill.

As honourable members know, this bill is a conscience vote for Liberal Party members and therefore the views expressed in the Legislative Council tonight are my own views. These views are formed from personal experience I have with my family and experiences that many have shared with me over the years both privately and publicly.

Those who have paid close attention to this matter would know that I have not supported any of the voluntary euthanasia bills that have come before the parliament since I was elected to parliament in 2010. I want to let honourable members know that I am likely to be voting differently this time, and I foreshadow that I will be supporting the second reading of this bill. I am keen to listen to the

explanation of proposed amendments, and then I will give it my full consideration on the third reading after the completion of the committee stage.

Given that this bill is highly sensitive and emotional to community members and given the diversity of opinions on voluntary assisted dying amongst health professionals, legal practitioners and religious groups, I want to thank everyone who has presented their opinions on this important bill. The research I have read so far is that an overwhelming majority of Australians—it was reported nearly 90 per cent of Australians—would support lawful voluntary assisted dying. Currently, only two states, Victoria and Western Australia, have legalised VAD.

Since 2016, there have been a number of comprehensive examinations of end-of-life care across different jurisdictions. These inquiries have found that a significant number of people are experiencing unbearable and unnecessary suffering at the end of life, despite the best medical care. There are hundreds of testimonies from people describing with great clarity the damage done in the absence of VAD laws, including profound trauma suffered by families and friends from witnessing agonising death.

I was with my beloved mother until her last breath in a hospital, and it was the most horrible and traumatic experience for me and my family. She passed away after two months of agonising and enduring advanced-stage cancer. In the last two weeks before her death, my mum was begging for a merciful and dignified way to die. She was completely aware of her surroundings; however, her last wish was not to be granted.

My mum was a beautiful woman who treasured life. She was one of those energetic seniors in her 70s who believed in positive ageing, living a happy and fulfilling life regardless of how old a person is. Even when she was diagnosed with stage 4 bowel cancer, she fought so hard and so desperately to live the remainder of her life until she no longer was able to do so.

The last two weeks of my mum's life were simply heartbreaking. She looked unrecognisable, miserable and totally helpless. Her illness took everything away from her. She was bony. Her skin looked bright yellow from liver malfunction. It was an incredibly stressful and emotional time to see my mum in such a terrible state. It was a humiliating experience for my mum as she lay there in the hospital bed, no longer able to eat properly, no longer able to go to the toilet or take a shower, and no longer able to care for herself. She was just waiting to die.

Australia has one of the best palliative care systems in the world. However, palliative care cannot help everyone. It cannot alleviate all suffering. In Palliative Care Australia's own words, 'While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimal palliative care.'

A voluntary assisted dying law does not replace palliative care, it simply adds one more end-of-life option for doctors and their patients to explore alongside palliative care. Palliative Care Australia's own investigation of overseas jurisdictions has found:

...no evidence to suggest that palliative care sectors were adversely impacted by the introduction of [VAD] legislation. If anything, in jurisdictions where assisted dying is available, the palliative care sector has further advanced.

As many joint committees or cross-party parliamentary inquiries on end-of-life choices found, Australian doctors already help dying patients to die more peacefully, but they do so unlawfully and without regulation, support, transparency or accountability. These practices put enormous risk and burden on health professionals. It should not be a crime for a doctor to help a dying patient die peacefully because it is the final wish of that patient.

For those doctors currently faced with the agonising choice of helping a patient to die and breaking the law, or abiding by the law and leaving that patient to die with great suffering, a voluntary assisted dying law provides protection. With safeguards introduced, there will be more than

protection because it provides guidance and opportunity to consult with colleagues and the family of the person who is dying.

If this parliament is to pass voluntary assisted dying laws, then the law must be designed to help some of society's most vulnerable people: patients at the end of stages of a terminal illness whose suffering is beyond meaningful medical help. It is important to everyone to be reassured that there are enough and multiple safeguards to be built into the legislation to ensure everyone involved is protected, and that no-one can abuse the system.

On the question of equity and fairness, many have expressed to me that the current situation in Australia regarding the assisted dying law is incoherent and inequitable. For instance, eligible Victorians have been able to seek medical assistance to die since mid-2019; Western Australians will have access to similar laws by mid-2021. However, around two-thirds of Australians, about 65 per cent, will be denied the same choice.

My dear brother is 56 years old. Sadly, he was diagnosed with cancer in 2019. The doctor said that he does not have much time to live. The cancer tumour has spread through his body and his brain—he is like a walking time bomb. We could lose him at any time. He wants to live for as long as he can to see his son graduate from university, and to spend time holidaying with his wife in retirement. Unfortunately, at the rate of his poor health condition he may not be able to achieve or see any of his dreams come true.

My brother has lived in South Australia since 1979, when our family migrated here, and South Australia is all he knows, everyone he loves is here, but he does not have the choice to die here the way he wishes at the moment. The question is: why should Australians in some states have access to lawful assisted dying, while others do not, simply by accident of where they live or by their postcode? This is considered unfair by my brother.

We have had many conversations around dinner tables in recent times. He says that he has never begged me in his life before, but he says that, as an elected member to the parliament, if I can change one thing, if I can at least help South Australia to introduce or pass a law, then he will be able to die in the state that he calls home.

My brother said that he and his family will move to Melbourne to live if this law is not passed, and of course I do not want him or his family to leave South Australia. I lost my mum a few years ago, and I lost my dad last year when he had a stroke. My beloved father, who has always been reasonably healthy, left the world suddenly and peacefully in November of last year. It was a blessing that his departure was a quick exit without the enduring pain that my mum suffered.

As Australians we have long accepted that we should be free to make our own decisions about how we live our lives. If we are in the end stages of a terminal or incurable illness, the vast majority of us believe we should be able to decide when we have suffered enough. Consistently reliable opinion polling over two decades reveals support for voluntary assisted dying to be in excess of 70 per cent across every state and territory. This is irrespective of variations in the questions asked and methodology used.

In recent years, that support has risen to nearly 90 per cent according to the 2019 ABC Vote Compass survey of almost two million Australians. This support, I believe, is also largely irrespective of religious beliefs. Christians have shown to be strongly backing assisted dying. ABC Vote Compass found that 76 per cent of Catholics and 75 per cent of Anglicans supported the statement that terminally ill patients should be able to end their own lives with medical assistance.

I have consulted widely with multicultural community groups. Many of them have not expressed a statement publicly, but many of the Buddhist associations and some Hindu association groups have conveyed their thoughts to me that merciful dying and assisted dying with compassion would

probably be a good way that patients have the choice, and it would be a wise and compassionate thing to do, otherwise it would be cruel and unkind for us to interfere with someone's choice.

The word 'voluntary' in voluntary assisted dying is the key to the legislation we are debating. You do not have to agree with assisted dying if you do not want to use it yourself, but if other patients feel that this is an option for them, then they can make that decision. From my own experience and the many tragic circumstances people have shared with me, I believe that every terminally ill person, no matter where they live, should have the same fundamental right to access more compassionate end-of-life choices, including voluntary assisted dying.

As I mentioned at the beginning of my speech, I will be supporting the second reading of this bill. I will give it my full consideration on the third reading after the completion of the committee stage.

The Hon. D.W. RIDGWAY (20:00): I rise to speak to the bill and indicate from the outset that I will be supporting the second reading, and most likely the third reading. I will not delay the debate particularly long this evening, but there are a couple of things. As other members who have been here the same length of time as I have have said, we have had this two or three times before. The very first time a euthanasia bill was debated, I voted with it.

The next time was only a few days after my mother had passed away and I had a personal problem at the time, being a bit raw with having lost a loved one. Even though my mother, from the discussions I had had with her—although she had quite severe dementia towards the end of her life—I think was a supporter of voluntary euthanasia, or voluntary assisted dying, at the time I was not confident that there were enough safeguards in place.

Of course, in the last 12 months we have had the select committee. I have been provided with the submission that the South Australia Police provided to the committee, which I think is important because there has always been a legal issue around some of the particular provisions that have been suggested in the past. I will not read much of it, but I will just read the second to last sentence:

SAPOL is supportive of a legislative scheme that would allow a person, under certain prescribed circumstances, to die with dignity under proper medical supervision.

In their submission, they talk about the number of suicides.

Everybody knows I live in the southern half of Adelaide. I will not talk about the suburb, but right next to our house one afternoon, I thought, 'That's strange, there's a car running right next to me.' It was probably not much further away than the Hon. Terry Stephens is from me; I was doing something in my backyard. A friend of our neighbour, who was living with him and who had been diagnosed with a terminal illness, had put the exhaust pipe of his car into his car, had, I think, a couple of glasses or maybe a couple of bottles of red wine and gone to sleep.

Of course, the police had to come and deal with it. The man had passed away and there was a whole range of issues that the police had to deal with. In their submission, they talk about the opportunities. If somebody wishes to access a voluntary assisted dying scheme, they said, they are supportive of a legislative scheme to allow a person, under certain prescribed circumstances, to die with dignity under proper medical supervision. I think back to the guy who was next to us. He was a good guy; it would have been nice to have been able to exit this world in a more dignified manner than going to sleep in his car.

I am also really comforted by having a Victorian scheme. I know it is always trendy for people in South Australia to say, 'Let's be the first state in the nation to do something.' I think we probably should reflect on some of the social reforms that Don Dunstan drove through this state. They were the first in the nation, and I think he and his party, and probably all South Australians, were quite proud of the fact that we were groundbreakers in some of those reforms, but I have always been a bit nervous about being the first state to do this, so I am really quite pleased that Victoria has done it first.

We have some data and we have been able to look at how their system works. I am not sure our little state needs to be at the cutting edge of these significant changes all the time, being, if you like, the guinea pig, so I was happy to see Victoria go down this path and that we have been able to draw on their experience.

The final comment I will make refers to an article in *The Advertiser* on 3 October last year. A very good friend of mine, Peter Johnston, who played football for I think Glenelg and South Adelaide but certainly was a SANFL footballer—and it is fair to say he is a bit of a rough and tough sort of guy—was very upset with the way his mother passed away last year. He rang me and said, 'Ridgy, I need to talk to a journalist. I need to talk to somebody so I can tell the story.' I rang the Hon. Tammy Franks and she gave me Rebecca DiGiromalo's number, and I sent it to Johnno. I said, 'Please, talk to her.' I will not read it all, but the article says here:

'The last two days of mum's life she looked unrecognisable—gaunt, bright yellow from liver malfunction and the 'death gurgling' coming from fluid in her lungs,' said Peter Johnston, 62, executive director of the Association of Independently Owned Financial Professionals.

It goes on:

'It is a disgrace that humans are put through this humiliation,' he said after burying his 89-year-old mother...last Wednesday.

Johnno said to me, 'Ridgy, whatever you can do, please support this.' He said, 'It was horrible.' In the COVID circumstances, he lives in Melbourne, and he was lucky, he could actually get back here to spend time with his mum, but he was one of the last people off the plane before the borders were shut, so it could have been that his mother passed away all on her own.

He is a big rough and tough footballer. 'A bloke's bloke' is the best way to describe Peter Johnston, but he was really touched by it, and I gave him a commitment that I would put his comments on the record. I will not read the whole article; members have probably already read it. I said I would put a couple of his comments on the record and pay respect to what Peter and his mother, especially his mother, went through.

With those words, I indicate I will be supporting the second reading, and I am probably almost certain to support the third reading.

The Hon. T.J. STEPHENS (20:06): I will be brief. This is not my first rodeo; I have voted on this principle a number of times. But I will put on the record some of the things that are important to me.

First and foremost, we have all heard stories about people who have been touched by loved ones who have died a painful death. I held my father's hand when he died in excruciating pain, and I believe that the palliative care was not what it should have been at the time. That withstanding, my father fought and fought for every last breath that he could take. Consistently, I do not vote for voluntary euthanasia legislation and I will not be tonight or at a third reading.

As legislators and as members of parliament we can get carried away with the thought of appealing to or appeasing the masses, but I put my head on the pillow at night and I will not do that on any night if one in 100 people or one in 1,000 people are encouraged to leave this earth because they have been encouraged to do so before their time. I will not be a party to that.

At different times people have said to me, 'Oh, but, you know, the legislation is almost foolproof.' Well, almost is not good enough for me. I think the sanctity of life is incredibly important. I have been consistent over my time in the parliament. I have been re-elected a couple of times. I have never shied away from the way I vote. I am not embarrassed about it, and I will be staying consistent to my beliefs.

The Hon. C.M. SCRIVEN (20:08): I rise tonight to speak on the Voluntary Assisted Dying Bill, and I would like to thank everyone who has made contributions and particularly those who have made contributions about their personal circumstances, which I think for most of us is never easy to do.

I think, however, it is very important that we look first of all at foundational principles when we are thinking about legalising euthanasia. Australia is a member of the United Nations and therefore has bound itself to the Universal Declaration on Human Rights. Articles 3 and 4 of that declaration describe the rights to life and liberty as inalienable rights. These are rights that cannot be alienated, a right of which the individual may not be deprived and of which the individual may not even deprive himself or herself.

As an example, it follows that one cannot give up one's freedom by selling oneself into slavery, even for a compellingly compassionate reason. If the state permits individuals to sell themselves into slavery, this would impede the state in protecting impartially the right to freedom of all other citizens and especially the most vulnerable. It is the same with the right to life. If the state allows some people to voluntarily seek the assistance of others to kill them, even for what is considered a merciful reason, then this impedes the state from protecting impartially the rights of other citizens not to have their life taken from them voluntarily.

In general, as a society we recognise that this right to life is inalienable and that we do not kill each other. A government's first duty is to protect each one of us impartially. Euthanasia fatally compromises that first duty of parliament. I know that some members do not accept the premise that euthanasia puts some people at risk but there is empirical evidence to prove that it does, some of which I will outline later in this contribution.

Legalising euthanasia or voluntary assisted dying involves important threshold questions. Former Premier Minister Paul Keating said this:

The justifications offered by the bill's advocates—that the legal conditions are stringent or that the regime being authorised will be conservative—miss the point entirely. What matters is the core intention of the law. What matters is the ethical threshold being crossed.

In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the...debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature.

These are principles that affect us all. Palliative care specialist Professor Odette Spruijt voices similar principles. She has worked in palliative care for over 25 years and says:

To regard those who are at the end of life as if they come within a different category of human, that the sanctions on deliberate ending of life that we (so far) accept in other stages of life no longer apply, is to fundamentally change our value system at its core. It is not enough to talk about patient choice as if autonomy means only me. Autonomy is also relative, we are relational beings, we depend on each other, and what we do affects each other.

Paul Keating noted the reluctance on the part of proponents to confront the essence of what they propose in this type of legislation, permitting physicians to intentionally end the life of patients or assisting patients to do so. He said:

Opposition to this bill is not about religion. It is about the civilisational ethic that should be at the heart of our secular society. The concerns I express are shared by people of any religion or no religion. In public life it is the principles that matter. They define the norms and values of a society and in this case the principles concern our view of human life itself. It is a mistake for legislators to act on the deeply held emotional concerns of many when that involves crossing a threshold that will affect the entire society in perpetuity.

There are two reports that are particularly worthy of note on the issue of voluntary euthanasia. The first is the report of the House of Lords Select Committee on Medical Ethics, which concluded:

We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

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

The New York State Task Force on Life and the Law, called 'When death is sought: Assisted suicide and euthanasia in the medical context', said:

Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. Nonetheless, these members have concluded that legalizing assisted suicide would be unwise and dangerous public policy.

What these are both referring to, essentially, is the concept that is sometimes referred to as the slippery slope. There are two meanings of this. The allegation of a slippery slope is proved if one can show either, one, that despite the presence of legal safeguards, the practice of euthanasia always involves alongside it the practice of non-voluntary euthanasia; and/or, two, that legalisation of voluntary euthanasia for some cases will lead to calls for euthanasia for increasing types of cases and especially for those who are not terminally ill, such as those with dementia.

Both of these propositions are capable of being tested empirically. The evidence is worth some time and attention. First, the issue of non-voluntary euthanasia. The Netherlands allowed euthanasia from 1984. The number of cases reported to the authorities in accordance with the law was 454 in 1990, and 424 in 1994. However, these numbers do not account for the total number of cases of euthanasia, only those reported to the authorities and considered for prosecution.

In most cases, doctors had stated the cause of death as being due to natural causes, despite the fact that they were not. Doctors said the reasons they had falsified the cause of death were, one, to avoid the fuss of a legal investigation; two, a desire to protect a relative from a judicial inquiry; and, three, a fear of prosecution.

However, the government conducted a survey under the supervision of the Attorney-General, Professor Jan Remmelink. The report is referred to as the Remmelink report. It showed that voluntary euthanasia was in fact accompanied by non-voluntary euthanasia. The number of physician assisted deaths estimated by the 1991 Remmelink committee report was 25,306, all of which involved intentional killing by act or by neglect, some voluntary and others non-voluntary.

They were made up of 2,300 euthanasia on request; 400 assisted suicides; 1,000 life-ending treatments without explicit request; 4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life; 8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient, with the

intention to terminate life; and 8,100 cases of morphine overdose, with the intention to terminate life. Of those, 61 per cent were carried out without consultation with the patient.

I appreciate there were quite a number of figures there, so I will just summarise: it included withdrawal of treatment as well as active euthanasia. To pull out the particularly relevant points: more people were intentionally killed by physicians without their consent than with their consent. The Dutch evidence shows us that in 1990 there were 10,558 cases where there was an explicit intention to hasten the end of life by act or omission, and 55 per cent were non-voluntary. This justifies the conclusion that it is impossible to quarantine non-voluntary euthanasia from voluntary euthanasia, and that where voluntary euthanasia is practised, more are killed without their consent than with their consent.

The Dutch report in 1991 concluded that the Dutch guidelines for carrying out euthanasia by a doctor 'are incapable of preventing abuse'. The survey bears out this conclusion by indicating the cardinal safeguards requiring a request which is free and voluntary, well-informed and durable and persistent have been widely disregarded. The relevant point there is that, regardless of what the law is saying, the safeguards are widely disregarded. Paul Keating puts it this way:

An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project - the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.

No law and no process can achieve that objective. This is the point. If there are doctors prepared to bend the rules now, there will be doctors prepared to bend the rules under the new system. Beyond that, once termination of life is authorised the threshold is crossed. From that point it is much easier to liberalise the conditions governing the law. And liberalised they will be. Few people familiar with our politics would doubt that pressure would mount for further liberalisation based on the demand that people are being discriminated against if denied. The experience of overseas jurisdictions suggests the pressures for further liberalisation are irresistible.

He quotes the former President of the Australian Medical Association, Dr Michael Gannon, who explained that the formal position of the AMA was opposition to interventions that have as their primary intention the ending of a person's life. Dr Gannon said:

Once you legislate this you cross the Rubicon [meaning a point of no return]. The cause for euthanasia has been made in a very emotional way and this is the latest expression of individual autonomy as an underlying principle. But the sick, the elderly, the disabled, the chronically ill and the dying must never be made to feel they are a burden.

Paul Keating further said:

Palliative Care has issued the most serious warnings. It says at least one in four Victorians who die each year (about 10,000 people) do not have access to needed palliative care, [that is one in four do not have access to needed palliative care] that access in aged residential care is 'very low', that between 2 and 10 per cent of older Australians experience abuse in any given year and that its funding is inadequate to meet growing demand.

Keating went on to state:

More people in our community will be put at risk by this bill than will be granted relief as its beneficiaries. This is the salient point.

The issue is not how many people will choose to die under this proposed law. It is how many people may die when otherwise they wouldn't..

Once this bill is passed the expectations of patients and families will change. The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against. A

change of this kind will affect our entire community not just a small number of dying patients. It is fatuous to assert that patients will not feel under pressure once this bill becomes law to nominate themselves for termination.

Dr John Keown has recently summarised the evidence of euthanasia as it is practised in the Netherlands today. He stated:

Despite the legal requirement that physicians end life only at the explicit request of the patient and report all cases, six large-scale official Dutch surveys have disclosed that since 1984 physicians have, with virtual impunity, failed to report thousands of cases, and have given lethal injections to thousands of patients without request. Dutch assurances when the law was relaxed in the 1980s that euthanasia without request would not take place, and would be prosecuted as homicide if it did, have long rung hollow. In 2016, Professor Boer, a former euthanasia review committee member, observed that of 45,000 cases reported to the review committees since 2002 only 75 had been referred to the prosecutors for breaching the criteria and none had resulted in prosecution.

I note that those being referred were those who were expected to need investigation. It continues:

The Dutch government's proposals in 2016 to extend the law to allow elderly people with 'completed lives' to access assisted suicide promises to lead to a further substantial increase in numbers, involving many people who could live [healthy lives] for years.

We see similar evidence in Belgium. The Federal Control and Evaluation Commission in successive reports 'confesses to feeling powerless' because:

...it does not have the ability to assess the number of reported euthanasia cases versus the number of euthanasia cases actually performed.

Evidence discovered in recent research carried out in Belgium suggests that around 50 per cent of euthanasia cases are not in fact reported. Why is this so? Research indicates the following reasons specified by physicians who do not report who are able to give multiple answers to the questions put.

The answers they gave as to why they did not report included that they did not perceive their acts as euthanasia, that reporting is too much of an administrative burden, that the legal due care requirements had possibly not been all met, that euthanasia is a private matter between physician and patient, and that they did not report the case because of possible legal consequences.

One of the arguments used in favour of the change in law in 2002, and indeed that we see now in regard to this proposed law, is that the illegal practice of euthanasia would be brought out into the light and controlled. Clearly, the law has not done that. Legislation alone does not seem capable of doing that.

In May 2010, another set of Belgian scholars reported their research on the use of life-ending drugs in the Canadian Medical Association Journal. These scholars asked Belgian doctors to fill out a questionnaire to see whether these drugs were ever administered to patients who had not requested them. Of the deaths reported to them where the administration of life-ending drugs was involved, we see that in nearly 32 per cent of cases, doctors admitted to administering life-ending drugs without the consent of the patient.

When life-ending treatment was carried out without explicit request, the matter had only been discussed—even discussed—with 22.1 per cent of the patients. The reasons given as to why the ending of life decision was not discussed with the remaining 77.9 per cent of patients were that the patient was comatose, the patient had dementia, the decision was clearly in the patient's best interests, discussion would have been harmful to the patient, and others.

The evidence that we should not just trust doctors and nurses is also revealed in Australian scenarios. In their report of a sociological survey on the attitudes and practices of medical practitioners and nurses in South Australia, Christine Stevens and Riaz Hassan found that 19 per cent

of medical practitioners and nurses had at some time taken active steps to bring about the death of a patient.

Their most striking discovery, however, was that 49 per cent of those who had done so had never received a request from a patient to take such active steps; that is, in our jurisdiction, South Australia, where euthanasia is legally prohibited, 19 per cent of the medical profession agreed they had been involved in euthanasia but half of those 19 per cent had done so without reference to the patients.

Dr Stevens, who was involved in conducting the study, revealed on radio and in private correspondence that at the time she conducted the study she was neither in favour of euthanasia nor was she opposed, saying, 'I was entirely neutral and impartial in my views, neither in favour nor opposed, until completion of the analysis of the survey results.' She formed her judgement to be opposed to legalised voluntary euthanasia because of her finding of views, albeit minority ones, that:

...poor quality of life, mental disability and physical handicap should be valid circumstances for active euthanasia, whether this was requested or not.

That was what she found in terms of attitudes here in South Australia. She continued:

Advocates of euthanasia often argue in its favour from the perspective of individual rights, autonomy and dignity, but the research demonstrates that these very principles are abused by its practice.

The very principles of rights, autonomy and dignity are abused by the practice of voluntary euthanasia. She said:

There is a danger that legalisation of active euthanasia, voluntary or involuntary, may expand the potential for further abuses. Further, I consider legalisation could undermine the value placed on human life, and erode our sense of security. We need to ensure that the state continues to protect people.

Yet, we hear arguments that the very fact euthanasia exists and is being practised now despite its illegality is a reason to make it legal. As stated by a number of earlier speakers in this debate and also those I have quoted tonight, why on earth would we expect that those who are already willing to break the law would cease doing so if we have legalised euthanasia and safeguards? Those safeguards would not be respected.

The second meaning of the slippery slope refers to the calls to extend the provisions. The evidence I have mentioned from the Netherlands and Belgium shows that, whatever the law actually says, euthanasia will expand beyond the original confines in the law. There will also be calls to extend the law. The contribution earlier tonight from the Hon. Frank Pangallo has already outlined various jurisdictions where euthanasia has been extended to include children, people with disability, people with depression or other mental illness and so on.

The Canadian government is seeking to make it legal for doctors to directly kill or assist the suicide of vulnerable people who are not terminally ill. If passed, the bill known as C-7 will remove the requirement for a person's natural death to be 'reasonably foreseeable' and let people with a disability, including those suffering from mental illness deemed to be incurable, access medical assistance in dying (MAID).

Heidi Janz is an ethics professor at the University of Alberta and chair of the Council of Canadians with Disabilities' Ending-of-Life Ethics Committee, and she called the plans irresponsible and extremely unethical. Having grown up among other children with disabilities, Professor Janz said:

...we all knew that some of us would live longer than others. But we also knew that all of us would live with the best quality of life possible...

But she confessed that she worries about the effect that expanding euthanasia will have on kids and youth with disabilities. She added:

What keeps me up at night is knowing that this is not the message the current generation of kids with disabilities is getting. Instead, they're hearing about parents requesting [medical assistance in dying] for their disabled kids.

It is these kinds of subtle messages that imply that some people's lives are not worth living, and it is the most vulnerable who will be affected by them. In Victoria, despite the short time that their voluntary assisted dying laws have been in place, we see that the Voluntary Assisted Dying Review Board has already recommended changes to the act to provide for the legal right for medical practitioners to initiate a conversation about voluntary assisted dying. That provision of course is constrained by legislation in this bill, and yet in Victoria they are already seeking to change that after only 18 months of operation.

Associate Professor Spruijt, who I mentioned earlier—and I remind members that she is a palliative medicine specialist and affiliated with the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne—says this:

True to expectations, the results of the first 12 months of Victoria's voluntary assisted dying laws have been presented in the media as an argument for the removal of some of the safeguards of the initial act. The narrative provided is one of unrelieved suffering unless more people are able to access this option more easily. This narrative would have us believe that 'if not voluntary assisted dying, then devastating deaths are the only alternative'.

As a palliative care specialist with over 25 years of practice, mostly in Victoria, I have found the institution of the Victorian law to have a devastating effect on my practice of palliative medicine. I have witnessed the devastating impact of this law on the cohesion of teams, on the relationships within clinical units, and as a cause of deep moral distress among many of my medical colleagues, for whom this law, and its accompanying narrative, is anathema to the very core of our sense of what it is to be a doctor.

She continues:

While I try to avoid the slippery slope terminology, I see so much evidence of this in the attitudinal creep associated with the implementation of VAD that I find it hard to not adopt this metaphor. The slippery slope refers to the normalisation of these practices as much as to numbers of people who are assisted to die. I have seen this in my workplace, as those of us who express objection to VAD are challenged as uncaring, dogmatic and confrontational, as our views as conscientious objectors are not respected. I have seen it in the documentation of 'consider VAD if appropriate' in a clinical note on a patient...That note was written by a junior inexperienced doctor—

which means that he would not have been able to actually implement that—

but it echoes the growing sentiment of normalisation and acceptance of this practice for the relief of suffering.

She says:

I feel deep distress when I see junior doctors respond to patients' expressions of a wish to die by [simply] beginning the VAD process. There is no longer the mental health review, no longer the palliative care pathway, now there is just the simplistic acceptance that a wish to die in a person with life-threatening illness can be taken at face value and acted upon. And that those of us who express a different response to end-of-life suffering are berated as obstructing the patient's free choice. If we follow...[the] narrative, our duty now is to grant this wish with expedition, without question or exploration of the many and often complex factors leading to this request.

Previous speakers have referred to remarks from the Chair of Victoria's Voluntary Assisted Dying Review Board, who said she has not found evidence of coercion. She is quoted as saying:

...it simply can't be done under this legislation, the safeguards are too rigorous and there are criminal penalties for any coercion.

Firstly, these comments were made after only 18 months of the Victorian laws operating, which is far too short a period to make meaningful conclusions. Secondly, the nature of coercion is such that it will almost always be incredibly difficult to pick up, for example, talking about how badly the person's illness is affecting family members, how crowded the hospital is with people awaiting beds, how difficult it is to get time off work to visit the sick person, how a relative is losing income because they are staying with the sick person.

Any of these and a hundred others can be a form of coercion and pressure and be incredibly difficult to pick up. One-on-one conversations with no-one else present will, of course, never be picked up by a review board. In the event that it ever made it to court, how can a court determine beyond reasonable doubt whether the intent was to coerce the sick person or the person making the comments was merely incredibly insensitive.

It is nonsense to claim that legislation can prevent coercion which is one of the compelling reasons why this legislation should not pass. Of course, after the act of euthanasia, how can it be verified that the request was fully voluntary, well thought out and not due to external pressure. The people who may exert pressure suggest family members are hardly going to admit to the fact when the subject of that pressure is now dead.

As we see from the various other jurisdictions however many safeguards are in place, they can be and are ignored. Again, it would be irresponsible of us to pretend that changes in attitudes will not occur as the normalisation of ending others' lives develops. One person wrote to me saying this:

We have seen with the release of the Royal Commission report into the care of the elderly that this vulnerable group to our horror have not had their wishes for good and dignified care leading up to end of life respected. What sort of subtle pressure from institution or relative could be brought to bear upon this vulnerable group if assisted suicide were an option instead of them taking up limited health resources to remain alive until their natural time of death.

So let us not delude ourselves that if this bill passes it will be the last we hear of this issue for years to come. There will be more attempts to expand the criteria or reduce what will be called the 'bureaucratic burden' or the 'barriers to access' or discrimination.

Allowing physicians to help patients end their lives also changes the practice of medicine and our entire culture. Our laws impact society as a whole and not just the small number of terminally ill individuals. Physician assisted suicide changes the culture in which medicine is practised. It corrupts the profession of medicine by permitting the tools of healing to be used instead as techniques for killing. It reduces patients' trust of doctors and doctors undivided commitment to the life and health of their patients.

VAD advocates argue instead that it increases the trust that doctors have compassion, although no evidence is offered for this. But the change in the doctor-patient relationship will have occurred. A person will go to a doctor knowing that the doctor thinks that some people's lives are not worth living which must beg the question, consciously or unconsciously, does he or she think my life is not worth living? Can I therefore really be confident that she or he will do everything to preserve my life and health?

We are told that the safeguards are rigorous. Whilst I will make some further comments at clause 1 and during the committee stage elsewhere on these, I will reflect on a couple now. The first is that doctors must consult a second practitioner and yet we know from the recent debate on abortion law changes that the requirement for two doctors to personally examine the woman seeking an abortion was easily circumvented.

Doctors reported that they just had a pile of papers on their desk at the end of the day that they signed as the second consultation without personally examining the woman at all. Indeed, we were told at briefings that the removal of the second practitioner provisions was changing the law to reflect what was actually happening in practice. Once assisted dying practices become normalised, there is no reason to think that a similar dilution will not happen.

The latest push for physician assisted suicide is opposed by many of the medical associations. I am advised that includes the World Medical Association, the Australian Medical Association, and the Australian and New Zealand Society of Palliative Medicine. The World Medical Association Declaration on Euthanasia and Physician-Assisted Suicide states:

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

The AMA states:

The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

And there are many others. Some are silent, but those that are silent say 'this statement should not be taken as explicit or implied support of the legalisation of physician assisted suicide'.

We are told that SAPOL supports voluntary assisted dying because there are currently suicides of people with terminal illnesses. Clearly, the support for VAD rests on an assumption that suicides will decrease if VAD was available. However, international studies offer no evidence of such a decrease. One of the few studies that has tested this theory, Jones and Paton's 'How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?', published in the *Southern Medical Journal*, found:

Legalizing PAS [physician assisted suicide] has been associated with an increased rate of total suicides relative to other states and no decrease in nonassisted suicides. This suggests either that PAS does not inhibit (nor acts as an alternative to) nonassisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.

Similarly, Victoria has not seen any decrease in the number of suicides since its introduction of legislation. However, given it has only been in effect for 18 months, I want to be consistent in suggesting that that is not something we can draw a conclusion from.

There is also the problem of the so-called Werther effect. This is the theory that hearing about suicides and the reasons for them can cause others with similar dispositions to have suicidal ideation and possibly attempt suicide. Members will be aware that this is why we have strong guidelines for media on how to report on suicides. Supporters of VAD argue that suicide is not the same as VAD. However much we may use language such as 'voluntary assisted dying' instead of 'suicide', the reality is that many people will see it as the same.

If I am having suicidal ideation am I not seeking to die voluntarily? If we support ending of life because of suffering, including mental suffering, for someone who has a terminal illness, why would we argue against the ending of life of someone who is also suffering, including mental suffering, and who after all will also die at some point in the future? However carefully we choose our words, the message is confusing and conflicts with our attempts to combat the rising rates of suicide in our state. Palliative Care said the bill 'sends the wrong message to people contemplating suicide and undermines suicide prevention efforts'.

There are also claims that assisted suicide is better for the family and loved ones of the person who takes advantage of it. There has been one significant study called 'Death by Request in Switzerland: posttraumatic stress disorder and complicated grief after witnessing assisted suicide'. The Journal of

European Psychiatry study examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.

The study surveyed family members or close friends who were present at an assisted suicide, with assessment of full or partial post-traumatic stress disorder and complicated grief. They were assessed at 14 to 24 months post loss. The results showed that 13 per cent met the criteria for full post-traumatic stress disorder, 6½ per cent met the criteria for subthreshold PTSD and 4.9 per cent met the criteria for complicated grief. The prevalence of depression was 16 per cent; the prevalence of anxiety was 6 per cent. The study concluded this:

A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

We have been told essentially that this legislation is inevitable. The implication is that it is sweeping the world and somehow we are being left behind. In fact, it has been introduced in only 10 countries—10 out of 195. The debate also tends not to concentrate on medical advances.

We heard at a briefing recently some heartbreaking stories, but several of them were from 40 years ago. I acknowledge of course that there are other more recent ones, but medicine has come a long way in both preventing and treating illness and disease as well as palliative care. We as a society are becoming better equipped to reduce pain and suffering and not less so. At a time when we are able to do more and more to relieve suffering, it seems it is almost counter to then be introducing voluntary assisted dying.

One person said to me, 'We often hear it said by people who support VAD that we treat dogs better than we treat those at the end of life,' referring of course to putting animals down when they are suffering from sickness or injury. Apart from the objection that some of us might have to comparing people with animals, I will continue the quote:

This simple statement seems appealing on face value, but it is worth reflecting that we also put animals down when we no longer wish to pay for their treatment and medical bills.

I would like to extend my sympathy to all who have experienced the death of a loved one, which is, after all, most of us. It is always painful to see. Every person is different and every circumstance is different. No-one wants to experience suffering themselves or to see suffering in others.

My own dear sister-in-law, Mary, died less than two years ago from ovarian cancer, a particularly painful disease. It was about three years from diagnosis to her death, and she left behind a large family, who were of course devastated by their loss. Her illness and deterioration was painful for her and painful to watch for all of us who loved her. She received wonderful palliative care. One of the nursing staff who cared for her in the days before her death told us how, despite Mary's own suffering, she had been a joy to care for.

I mention this as a tribute to Mary, an amazing and loving woman who I feel very privileged to have known. I mention it also because it is frequent that people who do not support voluntary euthanasia are accused of lacking compassion and told that they will feel differently when someone they love has experienced a painful disease, illness or medical condition.

Most, if not all, of us have experienced a loved one suffering in that way. In many ways, we would dearly love to be able to relieve that suffering, and voluntary assisted dying seems like a simple answer, but if we cross the threshold of legalising the killing of another, we abandon fundamental principles to the detriment of our community overall. That detriment includes putting the most vulnerable at risk. The evidence shows us that roughly half of those who die through voluntary

euthanasia legislation have not requested it. We cannot take that risk. It is not fair to those we love. It is not fair to those who have suffered and died. It is not the appropriate move for our society.

The Hon. C. BONAROS (20:48): I rise to speak on the Voluntary Assisted Dying Bill 2020. At the outset, I would like to make one point very clear: as I said time and time again on matters of conscience, my job in this place is not to impose my morals, my beliefs or my religion on others because I do not think there is any place here for judging others and their choices. It is certainly not my job to bring religion or any of those other beliefs to the table either directly or indirectly.

If the laws before us have a solid foundation, if there is overwhelming public support and if they reflect what the experts are telling us is possible, then the bills that we consider will have my support. I do not consider my role in this place as one that requires or expects me to vote according to any of those personal belief systems.

I will also put on the record what I do not want to see and what has always made this a particularly difficult issue for me when watching from the sidelines, and that is last minute amendments that are of a substantive nature. We have now had the better part of four months to consider the current proposal before us. I think that was done quite intentionally by the opposition leader in this place to enable us adequate time to carefully consider the bill, and for those of us so inclined to move amendments.

What has irked me in the past on this bill—every time it has been debated in this place—and indeed other conscience vote matters but especially this one, is the eleventh hour flurry of activity and amendments being thrown about on the floor during the debate in an attempt to get something up. With respect, I simply do not think this is the sort of legislation that benefits from such changes when they are substantive in nature.

While I am happy to indicate my in-principle support for the second reading of the bill, I forewarn members that I do not intend to extend that support to any changes that would fundamentally shift us from the model that was first proposed by the Hon. Kyam Maher. I would be extremely reluctant to extend that support to changes that come even close to doing that.

What has been consulted on, what we have had before us, is the original bill presented by the Hon. Kyam Maher. We have not consulted on the amendments that would alter the scheme in any significant way, not when those amendments are considered on the floor of the chamber and without appropriate consultation and not without the level of scrutiny that the current model has already been the subject of.

I think it is fair to say my position is very similar to that of the Minister for Health and Wellbeing in that regard. I do recall the comments he made when he spoke, so while I support the second reading of this bill I reserve my position on the third reading to see what eventuates in the committee stage debate, particularly around the issue of amendments.

As everyone has mentioned already, this is the 17th time that this issue has been considered by the South Australian parliament. A great number of those were championed by former members of this place, including the late Bob Such, Steph Key and Sandra Kanck, as well as the Hon. Mark Parnell. Earlier this month, Tasmania joined Victoria and Western Australia in becoming the third state to pass their own legislation. The Hon. Mark Parnell has likened this to pass the parcel. We know we will get there in the end, but we just do not know when.

What is overwhelmingly clear is that the majority of South Australians have indicated that they would like a voluntary assisted dying model in South Australia. The Roy Morgan national poll undertaken in 2017 showed 83 per cent of South Australians were in support of voluntary assisted dying. Overwhelmingly, South Australians are telling us they do not want to die in agony and they do not want their loved ones to watch them suffer in agony. They do not want this for themselves. They

want the option of a good death when their time comes, they want to pass away in the presence of their loved ones, and they want the option of a dignified death. It is the compassionate thing to do.

Even with optimal world-class palliative care, not all suffering can be relieved. Those of us who have had the tremendous misfortune of watching any of our loved ones die know what that process is like. We know what the breathlessness is like, we know what the severe pain is like, we know what it is like when they lose consciousness. None of that is pretty and none of us wants to watch our loved ones go through that. Importantly also, there are many of us who do not want to have to go through that agony.

It is not a case of one or the other—palliative care or voluntary assisted dying—we can have both. The reality in my view is that there is a very fine line between making a patient comfortable, relieving suffering, and hastening death. This leads me to the second point I would like to address, and that is what I consider to be the very thin and often blurred line between palliative care and voluntary assisted dying. In my opinion, that can be a thin line.

I have, like others, all the admiration in the world for people who work in palliative care—absolutely all the admiration in the world. I think it must be one of the toughest jobs in our medical profession that you can do, and I think it takes a very special sort of person to work in that area. They comfort our loved ones and us at our rawest and most vulnerable moments, they ease our pain through to our loved one's last breath and they ease, as best they can, the intolerable suffering our loved ones endure in their final months, weeks, days, hours of life on earth.

I am not questioning that the two issues are often conflated, but only in the absence of a voluntary assisted dying scheme. I appreciate that not everybody is going to agree with my comments on this. Others may wish to disagree with me, but if you have been through palliative care with a loved one I think it can become apparent that in many instances—not all, but many—if someone is gravely ill and they want to die, there is an amazing team of people who will help them through that process, an amazing group of professionals who will help families through that process.

Medical intervention will cease, and pain relief will be offered and then offered again and again until finally our loved ones take their final breath. It is very confronting. When your loved one can no longer make decisions for themselves, when they do not have the option of a voluntary assisted dying scheme, you will no doubt second-guess every single decision you make as a loved one when your family member no longer has the capacity to make those decisions for themselves—gut-wrenchingly difficult and heartbreaking decisions that you might know in your heart of hearts are right but you also know are seeing your loved ones to their final hours.

Throughout that process we place what I consider to be extremely unreasonable pressures on our medical professionals, on our doctors, on our nurses, who deal with these situations. If I say to my doctor, 'I want to die,' of course they cannot facilitate that request. But if I say to my doctor, 'I don't want medical intervention, I don't want fluids, I don't want oxygen, I just want pain relief,' the end result is obvious. In those circumstances, as long as the intent of the doctor at the time administering medication or removing oxygen is not to assist in bringing about the person's death, then there is nothing wrong with the actions of those medical professionals.

For many of us faced with that situation, nothing will change if this bill comes into effect, but I acknowledge there are many in our community who never want to get to this point in the first place. They want the choice to end their suffering in a different way. We may all have different beliefs about how we want our suffering to end in the end if we are in that situation, but I certainly acknowledge that there is an overwhelming proportion of the population who says, 'I want to choose to end my suffering in a different way.'

We need to ensure our medical professionals are provided with the frameworks that are required for both of those models. These are difficult debates. If they were not we would not be here debating it for the 17th time, our inboxes would not be exploding with emails both in support and

against voluntary assisted dying, it would not form the primary reason why some voters vote for one person over another, we would not struggle (as many of us do) with what we are being asked to legislate. It is difficult, there is no question about that, and I have no doubt that for many of us it is the most difficult of social issues that we have to consider.

Just today, I was reminded that for many of us the decisions we make on social and conscience issues like voluntary assisted dying are not only difficult but they can also be deeply personal. We have seen that tonight in this place with the stories we have heard from honourable members. Often, we are forced to vote on matters that confront us in our personal lives, and this is no exception. We cannot sit on the fence. At some point, we have to draw a line in the sand and make a decision in favour or against the law. The toll and the cost to us in our personal capacity can be significant. It can also give us the strength to push even harder for certain reforms.

I should say at this point that it is also why I am extremely grateful for the briefing sessions that have been offered to date, the one-on-one meetings I have had so far, and especially the sessions that were held during, I think, the last sitting week, when we heard from Dr Roger Hunt, Ms Susie Byrne RN and Reverend Michael Dowling. It would also be remiss of me at this point not to also mention the years of advocacy and, on a personal note, the patience shown by Ms Sandra Kanck.

She has given a great deal of her time over a number of years now—right from when I was a staff member to now—to engaging with me personally about the pros and cons of voluntary assisted dying. I am extremely grateful to her, and to others like her, and to Stephen Kenny, for all the time they have offered over a very long period of time in terms of providing the level of information I wanted before I stood up here today and outlined my position.

When I listened to the contributions to the forum, I did so with a great level of interest, mainly because they were able to articulate very clearly a number of factors that weigh heavily on my mind when I think about voluntary assisted dying. In fact, there were many things those experts and individuals said that struck a chord.

When Reverend Dowling spoke, he sought to address all present—those with a particular religious tradition and those without—and to do so in a way that moved beyond religious stereotypes, stereotypes based upon very vocal adherence to particular viewpoints, stereotypes that propagate the myth of a monolithic Christian view on social issues that all Christians oppose voluntary assisted dying, amongst other social issues. He said:

The Christian Bible says many things that have inspired and motivated the lives of the most sublime and saintly people. The Christian Bible has also been used to justify the most appalling and callous behaviour.

When we Christians feel compelled to offer ethical advice to the wider society, in this case ethical advice as to the sanctity of life, we would do well to remember Jesus' adage, an adage as relevant today as it was 2,000 years ago: we should first cast the log out of our own eye before seeking to remove the speck of sawdust from the eye of another.

He went on to say:

But when it comes to this specific case of VAD the Christian Bible says...precisely nothing. And so, just like other members of our pluralistic society, Christians need to examine the proposed VAD legislation on its merits and with a willingness to engage in some uncomfortable self scrutiny.

If hypothetically, I was a Christian who felt uncomfortable about voting in favour of VAD legislation, do I really believe that my discomfort is more important than the unrelieved agony of the person requiring VAD? We human beings are endlessly self-referential. Almost invariably, everything comes back to me.

I believe we each need to ask ourselves the fundamental question: what or whom do I see at the very centre of this debate? Is it my personal ethics? Is it my understanding of God? Is it my feelings

of discomfort? Or...am I prepared to move out of the centre? Am I prepared to see at the centre of this debate, not myself, but rather the person in unrelieved suffering who is requesting VAD?

Reverend Dowling went on to say that, when we speak about legislation pertaining to voluntary assisted dying, we are considering circumstances that none of us would choose for ourselves—namely, circumstances of unrelieved human suffering. If we are lucky, these circumstances will never befall you and I. Sadly, these circumstances do befall some people, and it is this unrelieved suffering of these people—not religious sensibilities—that must be our focus.

When suffering is intolerable, when suffering is unrelievable and when the person who suffers wishes fervently for their suffering to end, must not our society's compassionate and loving response be to ask: how can we help you to end your suffering? I understand the objections to a voluntary assisted dying scheme based on religious grounds, and I do not need to be reminded or educated about those. I respect those grounds.

By the same token, I acknowledge also that not all Christians share the same beliefs when it comes to this or other social issues. I say that purely as a point of reflection: I do not and cannot vote on any of these proposals before us based on religious views. I think the comments of Reverend Dowling are very noteworthy. For me, the bottom line remains that, while I find all of this information helpful, extremely helpful, and while it did strike a chord with me, it does not necessarily form the basis of any decision-making in this place. We know that if a person wants to die there are other less palatable options.

If I wanted to end my life now, I am pretty sure I know how I could go about it. If I was terminally ill and I wanted to end my life now, I am pretty sure I would know how to go about it. When my mother was in her final weeks, months and days, I am sure there was enough medication in our cupboards at home, by the bedside, for her to have done that herself. That is an appalling situation to put individuals in, but the reality is that, if that is what we chose to do, then we know that right now—and I am sure this applies to many of us here—we would have access to enough medication, enough tools, to undertake those steps, and it pains me to know that we have a system that cannot provide for that in some form of dignified way.

In its submission to the Joint Committee on End of Life Choices, SAPOL indicated its support, as has been noted already, for voluntary assisted dying legislation. I am sure, from all the speeches that have been made, that we have no doubt received or seen a copy of the letter from SAPOL's Assistant Commissioner for Police, Scott Duval, to the committee outlining SAPOL's position on the bill. The letter I have was dated February 2020, but I think it is as accurate today as when it was written. It starts by setting out the total number of deaths occurring in SA attributed to suicide for each of the last four years as follows: 2016-17, 205 deaths; 2017-18, 203 deaths; 2018-19, 238 deaths; and 2019-20, 90 deaths.

SAPOL figures further indicate that, since 1 January 2019, 10 people have taken their lives as a result of terminal illness. The age of those persons range from 63 to 88 years. A further seven people took their own life with the reason identified only as age. These people range from 71 to 91 years of age. The numbers are provided from the holdings of SAPOL, and not necessarily the State Coroner. Nevertheless, the main point of the letter is the fact that many deaths in these circumstances are undignified, they are unnecessarily violent, they are often committed in isolation, which on occasions results in the death not becoming known to others for some time. There may also be a degree of pain suffered, depending on the method and the level of expertise of the person when they take their own life.

It is hard for any of us who have not been in this unfortunate position, I think, to truly appreciate how gut-wrenching and how harrowing it is to be the one who finds a loved one who has taken their own life, to work on the frontline of our emergency services and have to attend the scenes where someone has taken their own life. I know our police, our ambos and our medicos are trained to deal

with difficult situations, but none of us are made of stone. I have no doubt that each death they witness is difficult, and that over time it gets all the more difficult to deal with, it gets all the more difficult to go home at the end of a shift and switch off or forget the heartbreaking scenes that they and families and loved ones have confronted that day.

While I am sure that we are all extraordinarily grateful for the emergency workers who do this work day in, day out, I would not wish it upon anyone. So, quite rightly, SAPOL pointed out that legislation will not provide for every circumstance; it will not guarantee that I will not go and do one of the things that I mentioned before if I found myself to be gravely ill or otherwise. But, regardless of the existence of a legislative scheme, there will be individuals who, while they meet the criteria, will chose to take their life outside the provisions of such a scheme.

People suffering and who meet the criteria will almost certainly be under the care of medical practitioners, suggesting that if they are so minded, that desire would be known by their treating doctors. It is no surprise then that SAPOL is supportive of a legislative scheme that would allow for a person, under certain circumstances that are prescribed, to die with dignity and under proper medical supervision, and I have no reason to believe that would not extend to the scheme that is currently before us.

Recently, someone I know very well received a dreaded phone call, when their extremely ill and extremely old dad, who was suffering immense pain and what I think he considered to be undignified pain, had had enough. He could no longer live with the pain he was enduring and tried to take his own life in an extraordinarily confronting manner. My heart broke for him, and also for his family, who had to watch their father suffer—and he continues to suffer.

I think his only wish to his kids is that he could do this in a dignified way, because for him he has reached the end of his life. There is nothing more that he would like now than to go to sleep and rest, but he does not have that option available legally and so, unfortunately, he tried to take his own life and was not successful. That has created a whole heap of new issues that that family had not been confronted with before. It has made his medical condition worse than it was before.

While voluntary assisted dying might not be my choice or your choice, I think we need to acknowledge that overwhelmingly there are many who want a choice. Without that choice, we can continue to expect police to be called out to scenes like the one that I have just described, where somebody has taken their own life or somebody has attempted to take their own life unsuccessfully.

Turning to the bill, I think it has been stated already that this is the most conservative model in Australia and perhaps around the world. It is, as we have said, a replica of Victorian legislation that has been in operation for almost two years. It does contain the 68 safeguards that have been referred to. It has the strict eligibility criteria. Disability or mental illness do not fit the criteria, nor does age. There are a number of other factors that have already been outlined, which I will not outline again. For those who do not agree with voluntary assisted dying, of course, the bill preserves their right to conscientiously object to those sorts of procedures if they are working as health practitioners.

The Victorian model, we know, has been reviewed by the Voluntary Assisted Dying Review Board four times to date. There have, as I understand it, been about 581 applications since the commencement on 19 June 2019. The most recent review considered activity from 1 July 2020 to 31 December 2020, and in that period the lives of 328 permit holders ended. A total of 56 per cent administered the medication themselves, 12 per cent were administered the medication by a medical practitioner, and the remaining 32 per cent died prior to the medication being dispensed. The average applicant age was 71, and 77 per cent had a diagnosis of cancer. Only about 2 per cent withdrew their applications due to a change of mind. Ninety-six per cent of cases retrospectively reviewed by the board were compliant with the act.

It is my view that we do not need to, and we absolutely should not, reinvent the wheel, nor are we considering legislation that does any of the things that we have indicated concern for. We are not legislating for a voluntary assisted dying scheme that would apply to minors. We are not legislating for a scheme that would apply to people with mental impairments. We are not legislating for a scheme that applies to anyone who does not meet the thresholds that have already been outlined.

As I said at the outset, I am not supportive of amendments that fundamentally change this bill. While I support the second reading, I will reserve my position on the third reading depending on the outcomes of the debate and depending on—I am not sure if there are going to be amendments moved.

I would just caution members against moving amendments that fundamentally shift us from a model that we know has been tried and tested to one that we have not all had the benefit of consulting on while we have had this bill before us for the last four months. I would not want to be making those decisions on the floor of this place at the eleventh hour before the debate is concluded. With those words, I look forward to the next stage of the bill.

The Hon. D.G.E. HOOD (21:15): I rise to speak on the Voluntary Assisted Dying Bill 2020, as a number of my colleagues have previous to me. Can I state at the outset that I will be using the terms 'euthanasia', 'voluntary euthanasia' and 'physician assisted suicide', etc., interchangeably. Typically when I am quoting, obviously I will use what was quoted, but I just want to state that at the outset.

I also want to acknowledge the sincerely held beliefs on both sides of this debate before I begin what you might call the body of my speech. I acknowledge particularly the Hon. Mark Parnell, who has brought a bill to this effect to this chamber on a number of occasions—three, occasions, I think, Mark?

The Hon. M.C. Parnell: Twice.

The Hon. D.G.E. HOOD: Two, I beg your pardon. Of course, both times we have voted in opposite directions on those bills, and I am sure we will this time as well. That will not change, I suspect. But I do want to acknowledge the strength of feeling on both sides. It is one of those very difficult debates that I think all of us in a sense dread but also in a sense look forward to in terms of putting our views on the record.

This may be a good opportunity for me to say that the speech I make tonight is not an attempt, necessarily, to persuade anyone. I do not think I am going to persuade anyone. I think people in this chamber have made up their mind, by and large, but it is an opportunity to put my feelings on the record about something that matters, I think, a lot to all of us.

The first thing I would like to say is that my speech does not specifically touch on the issue of advance care directives. I have deliberately segregated that from this speech because I think it is slightly different, but in some ways I think the availability of advance care directives does provide an opportunity to lessen the need or, in my mind, negate the need for something like physician assisted suicide, because if well handled and structured correctly, as I believe they currently are, they certainly at least reduce the need for euthanasia—physician assisted suicide. I think the Hon. Ms Centofanti explained that quite well, and I associate myself if not completely with her remarks certainly largely so.

As I said, I do acknowledge that there are many sincere people calling for voluntary euthanasia, not just in this chamber but in the broader community. Polls have often put the numbers supporting something like this in the order of 60, 70 or even 80 per cent on occasion. It is, indeed, a very difficult area, and I am sure everyone would acknowledge that.

I have listened respectfully to the arguments that have been put to me in favour of assisted dying for many years now. I have been in the parliament 15 years, as has the Hon. Mr Parnell—15 years last week, I think it was, or the week before. I know some people may doubt this, but I mean this quite

sincerely, hand on heart: I have tremendous sympathy for people who are suffering what they consider to be unbearably through disease, accident or otherwise.

Indeed, in my own experience I saw my very sick grandmother, my grandfather and my father-in-law pass away in recent years. No-one enjoys that. Who is going to enjoy that experience? It is a terrible experience. I would say that, fortunately, in my case two of those three deaths were what you might call good deaths or relatively good deaths, if there is such a thing. One was not so good, frankly.

How can it not leave an impression on you? It left an impression on me. As we have heard in accounts from members tonight, it touches you deeply and there are things that are very difficult to forget, as it has been for my family members as well as myself.

Despite these sorts of deeply personal experiences that I think we have all experienced at various levels, I maintain the position that allowing so-called mercy killing or assisted suicide sends the wrong message about the sanctity of life and that it will result in some elderly and terminally ill South Australians feeling they almost have a duty to end their life so as not to be a burden on others. I will expand on that in a moment.

It is my view that it is all but impossible to make sufficiently objective legislation for what is inherently a subjective issue. Indeed, it is not easy to sufficiently define 'suffering' in law, as people individually decide when they are suffering. What is severe suffering for one person may be deemed mild or moderate suffering by another. How can suffering be measured in any objective way? It is especially difficult to find an objective area of what constitutes unbearable suffering since individuals will react to the same physical or psychological situation in different ways. In short, people are different and making law that works objectively in a mostly subjective situation is near impossible, in my view.

There are many commonly held ethical arguments against the legalisation of euthanasia, not least of which is that it weakens society's respect for the sanctity of life, something that I feel strongly about. All human beings deserve to be valued regardless of their age, their gender, their race, their religion, their social status or indeed how well or unwell they are. Human life is a fundamental good in my view. It is a good in and of itself, rather than a means to an end. It is a gift and, I might even venture to say, it is sacred.

For very many years now, my view has been and remains that the deliberate taking of human life should be prohibited, with the only exception being when the act is in true self-defence or the genuine defence of others. If we end lives just because it seems the most effective way of ending suffering, then I believe we fail to respect the inherent worth of human life.

There are many what I might call usual and, in my view, compelling arguments against physician assisted suicide that have been made for many years now as these debates have circled the world. I have just outlined the first, which, to me, is that life is precious and indeed—here is that word again—sacred.

This is my primary philosophical objection to euthanasia. Looking at arguments that may be seen as less philosophical and more practical, though, should euthanasia be legalised, it will be virtually impossible to ensure that all acts of euthanasia will be truly voluntary. Also, the further liberalisation and expansion of the laws around this bill once enacted is all but certain, as we have seen from overseas experience.

The so-called slippery slope argument poses that we will almost certainly see vulnerable people who may be elderly, ill, lonely or distressed feeling pressured to end their lives and that so-called legislative safeguards, though well intentioned, can and likely will be dismantled over time.

Family or others involved with an ill or disabled person may consider them and their illness or injury as a burden on themselves and their family may pressure that person to request a quicker end, if you like. People who are ill and dependent can feel worthless and do not wish to be a burden on

their families and careers, making them potentially susceptible to such pressure, however subtle or not it may sometimes be.

The concerns I have outlined are not merely theoretical concerns but are supported by the facts. Indeed, it is extraordinary to note that in the 2013 official report from the Washington State Department of Health, entitled *The Death with Dignity Act Report* (number seven), which examines the actual experience of that state's euthanasia laws, states, and I quote directly, that '61 percent of those who chose assisted suicide stated as one of their reasons for their decision their feeling that they were a burden on family, friends and caregivers'.

The obvious and unmistakable conclusion from this official government report of their actual experience following legalised voluntary euthanasia is that around six out of 10 individuals who requested euthanasia feel pressure from family and loved ones to end their life when it is a legalised option. If it is not legalised, they do not have that option and there is no pressure. This highlights the concern that those who argue against euthanasia have, with the prospect of individuals being coerced into ending their life not just a theoretical risk but the actual experience of six out of 10 individuals who requested euthanasia in Washington, USA.

Of course, the problem of pressure from family members is not confined to Washington. A well-known case that demonstrates that—I will use her name because it is widely published, including in government reports—is that of Kate Cheney, who was 85 years old and diagnosed with terminal cancer. Kate lived in Oregon, USA, where euthanasia was also legalised.

Kate told her doctor she wanted assisted suicide. The doctor who took the request was not sure if she qualified because she was suffering dementia, which may have affected her mental competence to make that request. He referred her to a psychiatrist, as is required by the law in Oregon. She went to the psychiatrist with her daughter.

The psychiatrist found that Kate suffered from short-term memory loss and reported that his judgement was that Kate's daughter had shown more interest in arranging assisted suicide than Kate had. He wrote in his report, 'She does not seem to be explicitly pushing for this.' He also noted his opinion that Kate did not have 'the very high capacity required to weigh options about assisted suicide'. He therefore declined to authorise the lethal prescription.

Subsequent reports, all officially available through the government of Oregon, suggested that Kate seemed to accept the psychiatrist's decision, but, importantly, her daughter did not. In a media interview, Kate's daughter described the guidelines protecting her mother's life as 'a roadblock' to Kate's right to die. The daughter then demanded a second opinion, which was provided by a clinical psychologist who also expressed that Kate's decision 'may be influenced by her family's wishes'. Incredibly, despite this reservation by a psychologist who determined that Kate was sufficiently mentally competent to make the decision, she was given the necessary pills, which she took and died soon after.

How can it be guaranteed that exactly the same situation that I have just relayed, being a real case, will not happen in South Australia, should this bill pass? The obvious answer is it cannot be guaranteed. I have grave concerns that such circumstances will play out here, should this bill pass. These are uncomfortable conversations, but ones that must be had. It is not scaremongering. These are actual cases from the United States.

Is it not at least possible that other factors may play a role in creating a circumstance where coercion becomes a factor? It is not hard to imagine a circumstance where the person who may seek euthanasia possesses a high-value piece of real estate, for example. The property may have been willed to someone who stands to make a large financial gain when the individual passes. Whilst I have no doubt that many people would prioritise the life of their sick mother, father or other relative over any financial gain, the undeniable truth is that not everyone would.

We need to be at least honest and realistic in our deliberations and at least acknowledge that some will be willing to exert pressure on an individual to accept an early death to hasten their access to a substantial inheritance or even just to reduce the burden on themselves as just one possible example, and, of course, there will be others.

Again, the official government report from Washington state reported that 61 per cent of those requesting physician assisted suicide listed being a burden on family, friends and caregivers as part of the reason for their request to end their life. Further, medical and other care during the last few months of a patient's life are generally very expensive. They can be time consuming with hospital visits and the like and quite a burden on family. Euthanising a patient could be seen as a way of relieving pressure on family finances or even conserving scarce medical resources from a government perspective. The moral questions and dilemmas that may arise are significant and confronting.

We should also not attempt to convince ourselves that the actual process of euthanasia is straightforward and therefore that it is unlikely that little can go wrong once laws to legislate it are passed. The fact is that these laws always rely on the individuals involved to do what might be considered the right or reasonable thing and almost always rely on subjective judgements in very difficult, often complicated situations.

Real-world lived experience has demonstrated that things do not always go as planned and the outcome is not always a comfortable one. Proponents of legalised assisted suicide often point to Oregon as a shining example of how assisted suicide should be practised. They point to safeguards enacted in the law designed to protect patients. However, there are several examples of poor and questionable outcomes in Oregon too.

I cite the following example of Michael Freeland. He requested and received a lethal prescription from his doctor—who incidentally was a suicide advocate—a few months after being diagnosed with lung cancer. Over a full year after receiving the first prescription, Michael Freeland was admitted to a psychiatric treatment facility with depression and suicidal intent. He was treated and improved. His treating psychiatrist wrote a letter to the court the day after his discharge saying that he was not competent and needed a guardian; that is, he was not appropriate for euthanasia.

Positions for compassionate care volunteers helped him through his last several months of life, saw that his depression and his symptoms were treated aggressively and assisted him in reconciling with his estranged daughter. He died naturally and comfortably nearly two years—nearly two years—after receiving his first lethal prescription. Before he died he signed an authorisation releasing his medical records for public review. It has become quite a famous case.

I share these accounts, that of Kate Cheney and Michael Freeland, as examples of the types of scenarios we may witness if this bill is passed. Despite its best intentions—and I do not doubt that—and apparent safeguards, I believe this bill will inevitably fail the vulnerable as these real-life examples show in other parts of the world. Of course, these two examples are far from unique. There are several other examples which I will cite, all from Oregon, and all sourced from the Vermont Alliance for Ethical Health Care despite Oregon being touted as a model of success.

Mrs S (her name was not given) from Oregon had been struggling with a malignant lymphoma for three years. Despite the best efforts of several of her physicians, it had spread from her lymph nodes to her bones, brain and spinal cord. She had vigorous chemotherapy and radiation therapy. She had considerable pain, to be fair, but this was kept under adequate control—so it was reported—with medication. She was repeatedly feeling discouraged and this was helped somewhat by the use of an antidepressant.

In a final visit with her primary physician he gently confronted the fact that there was nothing more that could be done for the disease, although comfort measures and medications could be continued. At the end of the visit he said, 'Well, I could write a prescription for an extra large amount of pain

medication for you.' She declined the offer and left the office. Mrs S and her husband were devastated, I am informed. She kept saying, 'He wants me to kill myself.' They interpreted his offer as saying, 'Your life is no longer worth living. You would be better off dead.'

Their longstanding good relationship with this seemingly caring physician was shattered by this new understanding of his values. I am not saying every physician would be like that of course but this is an actual case and an actual response from a real-world situation. Mrs S died comfortably at home several days later.

I acknowledge that this bill requires the patient to raise the matter, not the doctor, but it must be noted that lobby groups in Victoria are already calling for this measure to be removed in their bill so that doctors can proactively raise the possibility of assisted suicide. Furthermore, as the case I have just outlined shows, it can substantially change the doctor-patient relationship. Despite the fact that in Victoria it is actually illegal for the doctor to raise the potential for physician assisted suicide with the patient, as I have just said the reality is that lobby groups in Victoria are currently lobbying to have that removed already, after their bill has been in place less than two years or thereabouts.

Another example is that of David Pruitt, a man from Oregon with lung cancer who obtained from a physician the standard lethal prescription and when he felt it was time he took the entire amount. He went to sleep for 65 hours and woke up and, so it was reported, said, 'What the hell happened? Why am I not dead?' He was so unnerved by the experience that he did not want to go through it again and he died naturally about two weeks later.

Another example is, soon after the Oregon law allowing a physician to write a lethal prescription for a patient went into effect, Helen asked her physician for one. She had a history of breast cancer and was enrolled in a hospice. She had been using a wheelchair for two weeks and had some shortness of breath for which she used oxygen. However, she had no pain apparently and she was still doing aerobic exercises regularly. Not surprisingly, her physician declined her request, thank goodness. Helen responded by consulting a second physician and he too declined because he felt she was depressed.

Following the refusal of two qualified doctors, as you might expect in these circumstances— she was after all doing aerobics exercises regularly—her husband called Compassion in Dying, a group that supports assisted suicide. They found a willing physician who wrote the prescription although the physician himself admitted he was shaken by Helen's eagerness to die. She went to two physicians, they said, 'No, you don't qualify.' They found one that was prepared to write the prescription and that was that.

That is Oregon and Washington state. Turning to some other international experiences, members will be aware that euthanasia has been legalised in Holland for several years. Dutch euthanasia expert Dr Theo A. Boer—I think I have pronounced it correctly—said assisted dying at his country had gone from being seen as a last resort to a 'project to be managed'. From 2005 to 2014 Boer was an ethicist on a regional euthanasia review committee in the Netherlands, examining some 4,000 euthanasia cases. He said:

I used to be a supporter of euthanasia legislation. But now, with 12 years of experience, I take a different view.

The availability of euthanasia has very much changed the way we think about dying. Dying is more and more kind of a project. It is something that people are managing. The initial reasons for euthanasia in the Netherlands was pain...People were beyond hope because there was no pain relief. But what I have seen is that the primary reason is not pain.

According to Boer's research, terminal cancer was the reason behind 95 per cent of cases of euthanasia in 2002 but only 68 per cent by 2016—95 per cent in 2002, 68 per cent by 2016. He said that since the Netherlands legalised assisted dying in 2002, there has been a consistent increase in uptake and also a shift from seeing euthanasia as a last resort to a so-called good death.

Proof of this can be seen by the announcement made by the Dutch government and reported in *The Guardian* that they intended to legislate to allow those who feel they have 'completed life' to qualify for voluntary euthanasia. A completed life is a new concept in international euthanasia legislation, despite initial assertions that the original legislation was enacted to deal with those in severe pain and assurances that that was where it would remain. This is around just 14 or so years after the original euthanasia legislation passed and despite assurances that the legislation would always remain narrow and was targeted specifically at the terminally ill, exactly as the bill before us does now. Things changed there very quickly.

Closer to home, the Northern Territory experience is also worth considering. As members would be aware, in 1995 the world's first euthanasia legislation, the Rights of the Terminally Ill Act 1995, was passed in the Northern Territory and saw several deaths until it was overturned by a 1997 commonwealth act. In the patient examples from the limited Northern Territory experience, four of the patients mentioned in a follow-up report were not in severe pain at all, despite the bill specifically requiring it.

In fact, the medical notes indicate that in one case 'the patient took morphine for generalised bone pain'. In another case, it was noted that 'pain was well controlled'. A case still proceeded where the patient 'complained of mild background pain'. Another case noted 'regular analgesia was needed for abdominal pain'. In each case, despite the low or controlled level of pain specifically indicated, the request for euthanasia was accepted. This is not what was promised when the bill was introduced.

Further, it is apparent that in two separate cases mentioned in the follow-up report there were symptoms of depression reported in those accepted for euthanasia, but no referral to a specialist psychiatrist occurred. What if the coordinating medical practitioner under the bill proposed before us determines that the criteria has been met yet fails to fully understand the full extent of the patient's depression, as the coordinating practitioner is not a specialist who treats depression but still deems a specialist referral unnecessary?

This was the experience in the Northern Territory, where patients suffering depression were not referred to a psychiatrist but were euthanised anyway. My concern is we may well see the same thing here. There are other examples I could quote, but these should suffice to demonstrate that, should this bill pass, we know what we should expect based on the actual experience in other parts of the world and indeed in the Northern Territory, that there will be cases in which a patient may ask for euthanasia or feel obliged to request it, even when it is not in the best interest.

What if the diagnosis is wrong and the patient is not terminally ill, or the prognosis is wrong and the patient is not going to die soon or in the time frame that the doctor suggests or determines? These circumstances do occur. Indeed, right now I have a personal friend who was told he had six to 12 months to live. That was 16 months ago, thank goodness. Whilst he has declined, he is still well enough to be at home with his family and enjoy regular dinners, frequent heartfelt discussions and just the simple pleasures of everyday life. He was given six to 12 months to live 16 months ago, in fact, almost 17 months ago now. Life and time are indeed precious to him, I assure you.

The question of medical competence must also be addressed when one is considering euthanasia legislation. Can we be sure that individuals are mentally competent to do so when they decide that their death is the best option? For example, *The Daily Telegraph* reported on 11 May 2016 that, in the Netherlands, the number of people who have ended their lives due to 'insufferable mental illness' has risen dramatically from just two individuals in 2010 to 56 people in 2015—just five years from two to 56.

Further, the international experience is that euthanasia laws can be quite narrow when initially passed, but they broaden and widen their reach the longer they remain law. Belgium is a case in point, where the number of reported cases of assisted suicide has risen, I think staggeringly, by

89 per cent in just four years, from 953 in 2010 to 1,807 in 2013. The latter figure, that is 1,807, represents nearly 2 per cent of all deaths in that country as being a result of voluntary euthanasia.

Further, Belgium further liberalised its euthanasia laws in 2014, giving doctors the authority to terminate a child's life if they requested it. Three children, aged nine, 11 and 17, were euthanised by lethal injection between 2016 and 2017, according to a report by the commission that regulates euthanasia in Belgium.

Substantial investment in high-quality palliative care can make euthanasia unnecessary, I would argue. The World Health Organization states that palliative care affirms life and regards dying as a normal process. It aims to enhance the quality of life for the family as well as the patient, of course. When made available to every patient, it will almost certainly reduce the desire to be euthanised and the number of requests. We simply must reach a position where palliative care is of the highest quality so that pain can be managed and the precious last stages of life can be of the highest quality possible.

My concern is that shifting the focus from palliative care to euthanasia will ultimately diminish the quality of palliative care. Health systems will become geared to providing the most cost-effective ways of dealing with dying patients. We are already seeing this in a very limited way in Victoria, where Palliative Care Victoria has examined palliative care funding in that state since euthanasia laws were passed, and they have reported:

There was a decline of 6.3 per cent after adjusting for cost increases in the funding for admitted palliative care. Overall, the result was a net decline of 1.5 per cent in DHHS palliative care funding allocations to these services.

DHHS is their department, and there is a decline in their funding of those services. We cannot allow this to happen in South Australia. In Australia, and especially in South Australia, we are fortunate that our palliative care services are amongst the best in the world.

I am convinced that a broader understanding of palliative care support services in our community would serve to erode support, or significantly reduce support, for euthanasia. People are naturally concerned about what might happen to them should they experience a life-threatening illness or severe injury. They deserve reassurance and care and not simply the availability of a hastened death, in my view.

I would like to make it clear that I am not advocating the unnecessary artificial prolongation of life. If, for instance, a patient wishes for their life support to be turned off, knowing that death will result, then I see no reason why the state should not accept that choice. I do not believe that artificial methods should be employed to prolong life where there are no prospects of recovery or indeed when the patient does not consent to medical intervention—that should be up to the patient.

Further, I have no opposition to medical practitioners providing a dose of medication, usually morphine, in order to attempt to treat a patient's pain, knowing that the dose used is so high that it is likely to end the patient's life—but only as a side effect of their attempt to treat that pain. If the treatment is required to alleviate suffering or for other medical needs, again, I am not opposed to it. If the intention is to treat the pain and not to kill, then I see no ethical difficulty with large doses of medications being used where appropriate. I am informed by doctors working in our health system that this approach is not infrequent.

It is important to note that the organisation that represents doctors in South Australia has made its opposition to euthanasia unambiguous. The Australian Medical Association (AMA) position statement on euthanasia and physician assisted suicide makes the following assertion:

The AMA believes that doctors should not be involved in interventions that have as their primary intention the end of a person's life.

It goes on to clarify:

This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

The position of the AMA is in agreement with my own view, as I have just explained. I believe that parliament should pause and carefully reflect before handing to doctors powers that their main representative body says they do not want. The position of the Australian Medical Association is not in any way an outlier in this debate. Indeed, it is similar to that of the American Medical Association and the British Medical Association. To be precise, the American Medical Association's policy on euthanasia states:

...permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The British Medical Association's policy on euthanasia states, and I quote:

Our policy position has been to oppose assisted dying in all its forms. We support the current legal framework which allows for compassionate and ethical care for dying patients.

During the recent abortion debate, the fact that the Australian Medical Association in South Australia supported the then proposed bill was presented as a reason to support that bill. Given that line of argument, the fact that the Australian Medical Association, the American Medical Association, the British Medical Association and, indeed, the World Medical Association, I am informed, oppose legalising euthanasia by precisely the same logic I submit is sufficient reason to oppose this bill.

I have serious concerns regarding this bill, which I have outlined. The bill allows active euthanasia on patients who may have more time to live than estimated by their doctor who in the end can only give their best guess. No-one knows exactly when someone will die. It can leave elderly and sick South Australians with the thought they are a burden and that the easy thing to do is to request a quicker end to their life, and that would be fully sanctioned and legalised by this parliament.

I can imagine the elderly and the weak feeling somewhat compelled in some circumstances—not all, I am not trying to overblow this, but there will be circumstances, as with 61 per cent in Washington State who said they did in the official government report. They felt in some circumstances that to opt for the option of ending their life was the right thing to do in order to relieve the burden that they were on others.

I leave members who are considering voting for this bill with one question: can they be certain that if they support this bill becoming law it will not lead to a single person being euthanased without their consent or because they felt pressured as a direct result of the passage of this bill? I do not believe we can with certainty.

I note that the bill before us does not require a referral to a psychiatrist but leaves the question of whether a referral is necessary to the treating doctor who may have limited experience in treating depression or may even be a suicide advocate in some cases. The same applies for clause 22(2) when an eligibility assessment is performed by the coordinating medical practitioner in this bill in relation to a patient's disease, illness or medical condition. Again, the onus is on the treating doctor to determine that eligibility is met for the conditions that can only be properly assessed by a specialist.

I accept that in many cases the doctor will be a specialist but it is not specifically required in the bill. Given that the outcome for the patient is potentially their death, this does not go far enough in my opinion. Also, I note that the bill allows someone as young as 18 to qualify for euthanasia. I understand that that is the normal age at which we would consider someone an adult and, therefore, there is almost a logic to that, if you like, in having someone as young as 18 to be able to request to end their life.

I ask the question earnestly: under what circumstances can society sanction the deliberate killing of someone as young as 18? Overall, teenagers' relative psychosocial immaturity makes them more likely to make choices on impulse, to focus on short-term gains, to be more susceptible to peer pressure, and to fail to anticipate the consequences of their choices. As I said, I understand that 18 is the age at which people are legally considered adult and the difficulty of choosing what must be another subjective choice of age, but any bill that opens this possibility for those as young as 18 must give even its supporters reason to pause and consider.

I could say much more but I trust that my contribution has sufficiently outlined my position. I oppose this bill because I believe it devalues the sanctity of human life and because, as we have seen overseas and in the Northern Territory, safeguards are not—indeed, cannot—be sufficient to protect the vulnerable and because, if passed, again as we have seen in other jurisdictions, the pressure to expand eligibility criteria will intensify.

Indeed, lobbyists in Victoria, despite the recent passing of their euthanasia laws, are already arguing for greater availability of access to euthanasia. Also, the safeguards are actually seen as roadblocks by some and that they should be removed. We have seen arguments to that effect in Victoria and elsewhere.

We should not be surprised by this. It was predicted by those who voted against the bill during the parliamentary debate in Victoria, just as those who do not support the bill are certain that it will occur in South Australia should this bill pass. It may be somewhat trite to say, but there is an old saying which I believe holds true here and that is, 'Where there is life, there is hope.' I certainly believe that is true and I oppose the bill.

The Hon. R.I. LUCAS (Treasurer) (21:48): At the outset, I congratulate members on the respectful way thus far the second reading debate of the bill has been conducted. Certainly, I have appreciated the considered submissions of a number of members whose views have accorded with my own but even some who have put a considered position diametrically opposed to the view that I have.

Mr President, as you are probably aware, I have been called many things over my long career in parliament but very rarely have I been called inconsistent. My views on euthanasia and related bills have been very consistent over a long period of time. I can clearly say I am the only member to have debated end-of-life issues through the 1980s, 1990s, the noughties, the teens and now the twenties.

My views have remained whilst the passage of the legislation has changed and morphed the eighties. The bill related to the Natural Death Act and then since the nineties, legislation in the mid-nineties and I think on two occasions we were asked to consider bills in the noughties, possibly three times—2000, 2002 and 2009, I think—and then again in 2010. I think for the last decade essentially the House of Assembly had the challenge of debating the legislation and now we have the legislation again 2021.

At the outset I want to state clearly, as I have on one previous occasion, that I stand in the chamber proudly as the product of my upbringing, my beliefs and my values. As a Catholic, I subscribe to the views generally—not always—of my church and my upbringing. I am very much a product of my family values and the upbringing imbued in me by my family both as a child and even in my early adult years.

I say that at the outset because they are the values and beliefs that I bring to the chamber in all that I do. I have on previous occasions rejected the view, and I do so again today, that in some way I as an individual member should park my religious views, my values, my beliefs or the product of my upbringing or what I bring to this chamber as an individual legislator to consider legislation. It does not and should not and need not dictate my views, but it is a significant influence for me in terms of how I vote and how I appreciate legislation.

I do not accept the view that, because I am Catholic, because I am religious, because I am a product of my family values, I need to park those particular views to the side as I consider legislation. That is important to me. As a result of that, I am a strange mix, as many might say. I am very much a fiscal conservative. In the truer sense of the word I have very liberal views on gambling issues, probably quite opposed to the views of the Catholic church that I am a member of. I have quite liberal views in relation to the views of—I will use a nice descriptor—the health conservatives who want to ban everything that might have sugar in it, so Coke, doughnuts and some of the joys of life.

Even though I have never been a smoker myself, I have always respected the individual, if they make a choice that they want to smoke, as long as they are not going to impact on others and we can park them off in the corner somewhere and they can go happily about their smoking or indeed eating their doughnuts or drinking their Coke, or whatever it might happen to be. That is a matter of freedom of choice. It is individual choice. To me, in the truer sense of the word liberal, I have very liberal views in relation to those particular issues.

I have very conservative views on the sanctity of life and moral issues and I am probably a product of my family upbringing, my religious views and my church. I proudly bring that to the chamber in terms of the debates that I have. I do not apologise for it; I never will, and I certainly do not intend to park those particular views as I consider how I am going to vote on particular issues.

The other thing I reject is the view that on every occasion—and this has been going on in every decade that I have debated this issue—in some way as an individual legislator the views of the majority expressed by either an opinion poll, market research or whatever else it is should dictate the way I vote. That is, I should park my own views and vote in a particular way because the majority of people in a poll say that I should vote in that particular way.

I have to respect those views, I need to have a look at those particular views, I need to listen to those particular views, but I do not have to accept—and I will argue till my last breath in this house; it is not too far away—that that is not what a legislator is elected to do. We are there to listen to those views and, if we want to, in the end make a judgement that that is a view we have. In the end, we can be judged by that, whether we support that view or whether we do not support that view. We will either be judged at an election or be judged within our own parties in terms of preselection in terms of those views.

I know that generally the majority view in relation to euthanasia issues is to say, 'You should vote for it.' People say to me, and very good friends and acquaintances say to me, 'The majority of people want it. You are honour-bound or obliged to respect the views of the majority.' We have opinion writers in the media who say, 'The majority of people say that they want this; therefore, it's your responsibility to vote for it.' No, it is not. It is our judgement as legislators to understand those views, listen to them and then form our views as individuals, and then we will be judged accordingly, either within our parties or ultimately in the electorate, in terms of the judgements we make on these issues.

I have recounted on a previous occasion people who say to me, 'Seventy per cent of people,' or whatever the number is, 'want you to support voluntary euthanasia. You have to', and I say to them, 'Okay, the same polls say to me that 70 per cent of people want capital punishment for terrorists who murder and maim children. They want capital punishment for serial killers who murder and torture young children. Should I support that?' They say, 'Oh, no, you shouldn't support that. You can't support capital punishment. That's cruel and unconscionable,' but the majority view in those specific areas would support it.

I do not support capital punishment. I never have, even if it was the majority view. One member of my former party room back in the eighties used to run very successful surveys in her electorate in the north-eastern suburbs, some of our more conservative areas over the years, with overwhelming support for capital punishment in certain areas—for killing policeman, killing children; it was a bit

before the terrorism days but for those sorts of areas. We were always asked to support capital punishment in those sorts of specific areas. I did not support it.

I supported, for example, the introduction of the casino to South Australia. I supported the introduction of gaming machines to South Australia, even though the majority view was against it. I was one of a small number of Liberals in this chamber in both cases who supported the introduction of the casino and the introduction of gaming machines. I am consistent in my view. I am a maddening confusion of values in a whole variety of areas, but I am unconcerned about supporting minority positions if that is the view that I strongly hold.

I know that in this particular chamber, whilst the view that I held years ago was the majority view in the chamber on euthanasia, it is very much a minority view at this particular time. However, I cannot, will not and do not have to subscribe to the view that, because a poll says that the majority of people say I should vote a particular way, that is the way I should vote on that issue.

I will not go through all the detail of the reasons why, because I have done it so many times over the years in relation to the legislation. This legislation is slightly different, and I therefore enjoy—others perhaps dread—the committee stage of debates on issues like this. Unlike the Hon. Ms Bonaros, I look forward to amendments teasing out potential changes to the legislation. I do agree with the position of the Hon. Ms Bonaros that amendments moved on the day or the day before do not give sufficient time for consideration and do not need to be and should not be given as much attention as those where due notice is given.

Credit to the Hon. Mr Maher, we now have a four-week break between the second reading vote and the commencement of the committee stage. I think I am correct, and he can correct me if I am wrong, that he has indicated the committee stage is likely to go over a couple of sitting weeks, so we do have a period of time when I would hope that people who subscribe to the view that I have—

Members interjecting:

The Hon. R.I. LUCAS: One week, is it? I am corrected: it is only going to be the one sitting week. Good luck with that in terms of getting through the committee stage in one week. Anyway, we will put to the side whether that is achievable or not. We are not intending to do an Hon. Mark Parnell and filibuster on the issue, but there are genuine issues that might need to be teased out. Anyway, I do look forward to the committee stage of this particular debate. Whilst I will not be supporting it, there may well be amendments which in my view make it a less unpalatable piece of legislation for those of us who have concerns about it.

Before concluding—as I said, I am not going to repeat all the detailed areas as to why I have consistently opposed euthanasia legislation over the years—a number of members over the years understandably have shared personal reflections which have influenced their views. For some, the personal reflections, not necessarily just of themselves but of friends and others, have influenced the changing of their vote on this legislation, and each of us is a product of what we have experienced.

I can say at the outset that my views have not been influenced by any personal experiences with end-of-life issues. As I outlined earlier, my views have been a product of my views on the sanctity of life that I bring to the table as I consider issues like this, but for a different reason I do want to share a personal reflection that relates to my mother's passing.

I make no criticism of the very excellent specialists we have here in South Australia, who may consider judgements in relation to their diagnosis, so I do not want anything I say (and I have never reflected on this before in any way) to be a criticism. The diagnosis my mother had many years ago, with the very best of specialists, oncologists and the like, was that she had ovarian cancer that had then spread to her lungs. She declined over a long period of time and was hospitalised for a long period of time as well.

My mother, being a kidney patient for many years with diabetes, was a dialysis patient. Dialysis patients have the wonderful option, if you want to look at it that way, of choosing whether or not to continue with dialysis treatment, and she was given that option by her specialist. She was diagnosed as terminal. As I said, in the original stages, ovarian cancer was the diagnosis and then there were spots on the lung, so the diagnosis—again, the very best of specialists, no criticism at all, made considered judgements—was that her condition was terminal.

So she had the option, but in this case it was her decision. I am sure she knew what the views of her children were, my views in particular and those of others, but ultimately she continued with her dialysis treatment even though she had had this diagnosis of being terminal. It got to the stage, for those of us who are Catholic, where the family was dragged from all over the state, the lights were drawn, the grandchildren had done their last farewell postcards on the wall and everyone was understandably quite sad. The Catholic priest came in and delivered the last sacraments and everyone came together to say goodbye.

That was the position she was in for a few days. Then, ultimately, we had forgotten that one of the specialists had sent off a culture some weeks before (and I am going to get this wrong because I am not medically inclined) for something that diagnosed the spots on the lung, and it took two to three weeks for those results to come back.

The results came back and they came to us and said, 'We've just diagnosed the fact that she's got tuberculosis. We don't think she's got cancer.' We said, 'Okay, what does that mean? That doesn't sound very good.' You say, 'Okay, she doesn't have cancer but she's got tuberculosis.' 'Oh no, tuberculosis we can treat with massive doses of antibiotics, pump her full of antibiotics, and there's a pretty good chance that she can survive.' It is quite contagious obviously, a bit like COVID-19 I suspect, almost, the early stages of that.

The reality was evidently unbeknownst to us that my mother, as a Japanese national living in Mukden, Manchuria, as a young woman had contracted tuberculosis and she had survived that. Evidently, kidney disease later in life can sometimes activate or reactivate tuberculosis. No-one told us this, of course, until they had done this particular diagnosis. So the reality was that they pumped her full of antibiotics and she lived on for a number of years afterwards. She saw a couple more weddings, a few more grandchildren being born, and lived a good life until she eventually passed away a number of years later as a result of a whole variety of complications to do with kidney-related disease.

So with the very best will in the world mistakes are made by the very best specialists in a very good health system that we have got in South Australia, and frankly in Australia for that matter. In different sets of circumstances other people confronted with the same situation might have made other decisions in relation to it based on, ultimately, honest mistakes being made by medical practitioners and the very best specialists that we have.

I have never shared the story. I know others have shared the story which has influenced their decisions. This has not influenced my decision in relation to euthanasia and end-of-life stories, but I only share it because it is probably my last opportunity to debate, hopefully, end-of-life issues in the parliament and to at least place on the record that there is an alternative set of circumstances that all of us need to contemplate; that is, that our very best medical specialists do not always get it right.

There are some people who are going to be diagnosed as terminal, and they will make judgements and decisions on the basis of that and what might be coming, and what they are experiencing, and then ultimately you find out later that the diagnosis was wrong in relation to the particular issue. So it has not changed my view in relation to this. It has obviously reaffirmed it, I suppose, but my views on euthanasia have been expressed on many occasions over many years prior to that particular personal experience with an end-of-life issue.

I will obviously vote against the third reading. I am not going to oppose and vote against the second reading because I look forward to the committee stage of the debate. I do hope some members will move amendments to seek to make, from our viewpoint, some aspects of the bill less unpalatable. They will have a slim chance of success, I suspect, knowing the majority view in the Legislative Council, but nevertheless they should be aired. As we saw in other legislation recently, amendments were moved in this particular chamber then were subsequently—some of them, anyway—successfully moved in debates in the House of Assembly.

The ventilation of those particular issues in this chamber, and the capacity to consider them and see the answers for and against, I think can assist the further consideration of the bill in another place at a later stage. With that, I indicate I will not oppose the second reading but I will vote against the third reading.

The Hon. K.J. MAHER (Leader of the Opposition) (22:09): I wish to thank all members who have made a contribution over the last two Wednesdays of sitting. It has I think been conducted in a very edifying manner. There has been high emotion, and that quite rightly comes with discussing issues around death. It was noted as part of the committee that it is not something we do well as a society, talk about how life ends and what we go through when life ends, but I think the fact that we can do it respectfully and have differing opinions here says good things about how this chamber operates.

Many of the speeches that have been given are particularly personal and touching, talking about people's life experience and, in fact, how a particular experience with loved ones, parents and others, changed views and influenced the way people see this issue.

One of the most important things is the name of this legislation: voluntary assisted dying. It really is in the name, 'voluntary'. Nothing we decide here, nothing in this bill, will make anyone do anything. It will not force any terminally ill patient to avail themselves of a scheme for assisted dying. It will not force any health practitioner to participate in a scheme if their conscience does not allow them to. However, making a decision against this bill certainly will actively stop people who wish to avail themselves of a voluntary assisted dying scheme in the last months of a terminal illness.

I want to very quickly talk about a few things the Hon. Connie Bonaros and the Hon. Rob Lucas said about when we come to the committee stage on the next Wednesday of sitting, 5 May, particularly in relation to amendments. It would be my view, and I suspect it would be the view of most people in this chamber who support this bill, that an amendment would have to be pretty extraordinary and backed by some significant health advice and expertise to be considered.

As the Hon. Mark Parnell has pointed out, this bill really is a carbon copy of the Victorian bill. The Victorian bill went through a lot of processes. In its formulation it went through a select committee, like we did here, of the Victorian parliament. The fact that the Victorian scheme has now been operating for some 18 months and has had four reports on its operation has given a degree of comfort to some legislators, not just in this chamber but in the other chamber, that there is an Australian context, that this does work and is as safeguarded as it can be.

As other people pointed out—and I thank the Hon. Stephen Wade for his contribution—we are following what can be termed 'the Australian model'. As I said, Victoria has had a scheme operating for 18 months now, Western Australia passed a scheme some time ago that will soon come into operation, and just last week Tasmania passed its voluntary assisted dying laws. It was an election promise of the current Queensland government to consider an early scheme, and I think New South Wales is about to introduce a scheme.

Where once we would have been first in any of the other 16 attempts that have been made over the last quarter of a century or so, we are now midfield, and following what has been a tried and tested formulation of what the health minister loosely, and correctly, terms 'the Australian model' for voluntary assisted dying.

This will be the conclusion of the second reading and, from indications of members, it seems to me that the second reading vote, if I can count properly, will pass with a significant majority. After that we will move into the committee stage. Because there is not a formal way to co-sponsor a bill, I think the Hon. Mark Parnell might make a contribution at clause 1 similar to a second reading sum up in relation to this.

I want to sincerely thank the Hon. Mark Parnell. He has done a lot of work on this over many years. He has described it, at some stage, as being a bit like pass the parcel: it is going to stop somewhere, and this legislation will pass the South Australian parliament. In his view, and in my very strong view, it is not a question of if that happens but a question of when that happens. Hopefully, Mark, it will be this time, but I am severely disappointed that you are cutting and running and not sticking around for the entirety of this bill. However, I look forward to you giving some reflection on this at clause 1 in just a moment.

From there we have indicated that if possible it would be good to wrap up clause 1, but I appreciate comments that others have made to perhaps not cut off the end of clause 1 tonight. There are some reasons for that. It might be beneficial so that the contributions people make on the operation of the scheme in the whole of clause 1, if there are questions that need further answers, then probably in that month we can get very concise answers and it will not take as long when we come back on 5 May. So we can reasonably quickly provide some of the answers to anything that is raised on how the scheme in totality works, and then move through the rest of the committee stage.

Given that it has been a number of months since, I think, 2 December, when this was first introduced into this chamber, there has been ample time for members to reasonably consider, and that has been reflected in the second reading speeches members have given. They have had time to thoroughly look at and consider, research and give their reflections on this piece of legislation. It is difficult to imagine that we would see amendments put on the day or the day before, given the long gestation period we have had for this bill.

As the Hon. Rob Lucas pointed out, they will very likely find even less favour with this chamber if they are put on the day or the day before. It is difficult to see a reason why we would not wrap up on 5 May. It is unusual that we have already had this. This will be the third week of sitting in which we have considered this bill, so I look forward to the passage of this bill and to getting to the third reading vote. At some stage during tonight—and there is a reasonable prospect we may be sitting—

The Hon. R.P. Wortley interjecting:

The PRESIDENT: Order! Turn it off!

The Hon. K.J. MAHER: —later on Wednesday 5 May than we often do, but that is the way that many of us understand we occasionally operate in this chamber when it is necessary. I will very quickly address in a brief way a couple of the comments people have made—

The Hon. R.P. Wortley interjecting:

The PRESIDENT: Order! The honourable member should take the phone outside.

The Hon. R.P. Wortley: It's Ridgway, playing games!

The PRESIDENT: Order! I have said before that members should learn how to turn their phones on to silent.

The Hon. K.J. MAHER: There were a number of common themes that people raised that are worth touching on, and when we come back on 5 May we can expand briefly further on those if people raise them in a moment at clause 1.

The slippery slope argument has been mentioned a number of times tonight, that in some way it will be irresistible that the scheme will be broadened over time. When the Victorian legislation was being debated, ABC Fact Check had a look at, I think, Paul Keating's comment, which has been

referred to tonight. I think Paul's Keating's comment was the claim that further changes will be irresistible and there is that slippery slope.

ABC Fact Check said that that claim does not check out in evidence from around the world. ABC Fact Check pointed out that there had been some changes in Belgium, in the Netherlands further guidelines had been published, but in most jurisdictions where assisted dying has been legalised little has changed regarding what practices are allowed or who can access assisted dying.

I know much has been made of particularly the experience in the Netherlands. Much more analogous to what Victoria, WA and Tasmania have passed are the schemes in the US. ABC Fact Check concluded that there has been no further liberalisation in any of the eight states involved in the US—and this includes Oregon—ABC said during debate on the Victorian laws in 2017, where the system has been operating since 1997.

Another common theme in contributions was about the experience in the Netherlands. A couple of contributions talked about figures and anecdotes from the 1980s and 1990s in the Netherlands but, as the Hon. Dennis Hood correctly pointed out, the Netherlands only had a voluntary assisted dying scheme in 2002. I think it passed the parliament in the Netherlands in 2001 and came into effect on 1 April 2002. Quoting statistics or evidence from the 1980s and 1990s in the Netherlands I am not sure makes a lot of sense, given the scheme did not start until 2002.

There have been quotes from the views of medical organisations around Australia and around the globe on voluntary assisted dying. It is true that the Australian Medical Association has a stance against voluntary assisted dying, even though 30 per cent of members surveyed by the AMA in 2016 favoured the AMA supporting or taking a neutral stance on VAD, and 51 per cent of members in that survey agreed that VAD can form a legitimate part of medical care.

Most other organisations take a neutral stance. Some are supportive, but most others are neutral. The ones that are neutral or supportive include the Australian Medical Students' Association, the Australian Nursing and Midwifery Federation, the Health Consumers' Council, Palliative Care Australia, the Royal Australian College of General Practitioners, the Royal Australian College of Physicians, the Royal Australian and New Zealand College of Psychiatrists and the Pharmacy Guild of Australia. They take a neutral or supporting stance.

There have also been suggestions, as a theme in some of the contributions, of potential misuse or abuse and particularly the potential for coercion in a voluntary assisted dying scheme. I cannot remember the contribution, but one contribution, I think, pointed to the quote from the Chair of the Voluntary Assisted Dying Review Board, Betty King, whom I think those who served on the Joint Committee on End of Life Choices had the opportunity of meeting and talking to when we went to Melbourne to have a look at the Victorian scheme. I think the Hon. Dennis Hood and the Hon. Mark Parnell were both on that fact-finding trip to Melbourne.

Certainly, I think we were impressed with the forthrightness and tenacity of former Supreme Court judge Betty King, whose quote in one of the early reports on the operation of the scheme talked about pressure being placed on terminally ill people to end their lives. About that question of coercion, she said, 'I have not seen—and I have been looking, believe me—I have seen no indication of any type of coercion.' When the honourable Betty King says she has been looking, I do not doubt she has been looking.

I do not have the quote here, but I think it was from the most recent, only weeks ago, report from the Victorian scheme, and again the chair of the review board, former Justice Betty King, talked about the argument that had been put up before the scheme was introduced about the possibility of coercion. It often takes the form of the possibility of children who stand to inherit money from their parents placing pressure on their parents.

Betty King made the comment that the evidence just does not bear that out in Victoria. She talked about the fact that, if anything, it goes the other way, that there is pressure from children put on parents who have decided to avail themselves of voluntary assisted dying when they are at the end stage of a terminal illness and are suffering intolerably. She went on to say that after talking with the doctors and their parents, almost always the children understand their parents' wishes. That issue of coercion has been borne out, not in the way that I think most fear, and that is a coercion or a pressure to avail yourselves of voluntary assisted dying, but in the opposite way; that is the evidence from Victoria.

There have also been suggestions about whether we trust doctors to involve themselves and make these decisions. I absolutely trust doctors to do this. Doctors are involved most days of the week in exceptionally difficult decisions, decisions that deal with life and death. Doctors regularly now make decisions in consultation with their patients, as people mentioned here, that are sometimes termed 'passive assisted dying', the refusal of medical treatment, which as people have noted—I think the health minister and the Minister for Human Services both noted—is regularised in legislation in the Consent to Medical Treatment and Palliative Care Act.

A patient can make the legitimate decision to refuse medical treatment, and a doctor in South Australia is obliged to follow that request from the patient. A patient can refuse that medical treatment to passively assist their dying even though medical treatment may involve saving their life. Doctors make these decisions without the safeguards and the protections that this act now affords.

I trust doctors, and I think most of us here do. We recognise doctors as doing what is in the best interests of their patients. If an argument is made that we cannot have this scheme because we do not trust doctors, then I think we are in a lot of trouble with how the medical profession runs in general.

With those brief remarks, I again thank members for their contribution and look forward to the start of the committee stage in just a moment, should the second reading vote go as members have indicated, and I look forward to members' questions about how the scheme in total might work and then, on the next Wednesday of sitting, on 5 May, delving into those individual clauses, the nuts and bolts of how this scheme works.

We are fortunate that we have the Victorian experience to fall back on in answering a lot of those. This is not, as it has been every other time, a more esoteric and hypothetical debate. There are things that we can now talk about in terms of how the scheme operates, and I look forward to that.

It would be my suggestion that if members have thoughts about amendments, I think it would be a courtesy to everyone in this chamber if they filed them, I would suggest, at least one week before the sitting week. The bill has been before the council since 2 December, and a draft of the bill we now see, which did not change very much, was distributed to members some months before that. I thank members for their contributions. It is time to get this done.

Bill read a second time.

Committee Stage

In committee.

Clause 1.

The CHAIR: I should indicate to the committee that there are 115 clauses, one schedule and, at this stage, no indicated amendments. As has been flagged, it is I think generally agreed that we will be considering only clause 1 this evening.

I have considered the suggestion that the Hon. Mr Parnell may wish to make some remarks as the co-sponsor in an extension of the second reading summary, and I am happy to accept that. However,

for the remainder of our consideration this evening on clause 1, I would ask members that they restrict their contributions to seeking information that I think the Leader of the Opposition, the Hon. Mr Maher, has indicated will be responded to in due course. I am not going to tolerate further second reading contributions at this stage other than from the Hon. Mr Parnell. So I call the Hon. Mr Parnell.

The Hon. M.C. PARNELL: Thank you, Mr Chairman. I will not take a long time, but I do appreciate the concession given to me as a co-sponsor of the bill and someone who, as matters have turned out, will not be here for the detailed debate in committee. That is disappointing, but I think in the nature of anyone retiring from parliament, there will always be unfinished business, and if it was not this bill, it would have been another one.

I want to just touch on a couple of things briefly. A couple of members in their contributions referred to some comments that I made recently, which, taken out of context, might appear a little bit flippant, and that is that I have considered this debate a little bit like a game of pass the parcel. Taken out of context, someone might unkindly think, 'He is likening it to a children's game; it's not an important issue.' It is the opposite: it is a matter of life and death.

My reference to pass the parcel was my confidence that the eventual passage of this bill is inevitable. The reference to pass the parcel is that we know there is a Freddy Frog in the middle of that parcel as it goes around the circle and each of the layers is unwrapped. Eventually, someone will get that. It was a reference, if you like, as other members have referred, to all the preceding members who have moved so many bills over so many years. Eventually, the music will stop, the final layer will be unwrapped and a bill will go through this parliament.

My confidence in saying that is in relation to the fact that, having been through a few debates—not as many as the Hon. Rob Lucas—in my experience, I think there was nervousness amongst members in being the first jurisdiction in Australia to do something like this. I understand that. Often, we are very proud of being first with things, but sometimes we are also nervous about it as well. Here we are in 2021 and South Australia is not going to be the first state to legislate voluntary assisted dying. We are not going to be the second state—in fact, we are now in the middle of the field.

Where I think this bill stands a greater chance than any other is the fact that the Hon. Kyam Maher, in consultation with the South Australian Voluntary Euthanasia Society, with me, with other members and, in fact, with so many people, has come to the conclusion that a conservative model, as went through the Victorian parliament, is probably the way to start, especially because, as the honourable member referred to, they have their regime of the review board. That review board has reported a number of times.

It was a privilege to meet Justice Betty King. The honourable member wrote down her words a bit more carefully than I did. In relation to coercion, I wrote, 'Did coercion exist? We didn't find it, and it wasn't for want of looking.' I got the feeling that we had this very feisty judge who was forensic in her examination of the cases that had come before her and had not found that problem.

I think taking the Victorian model does make our job easier in some ways because it is a model that has passed another jurisdiction with a bigger parliament than ours. I had one of my research staff extract the entirety of the debate in Victoria. I think it went to about 500 A4 pages in 12-point font. There is a lot of material there. We also extracted every question that was asked in that lengthy committee stage and in the different second reading contributions because we do want to get this legislation right.

I made a valedictory speech a bit earlier today and I talked about the importance of us as legislators in getting the detail right. To be fair, I think this is probably the first debate I have been part of where the detail actually looks to be something that is going to influence the decision that members make. I would like to think that people would agree with my analysis but, in the past, people have

either been for or against, and the detail has not been what has changed anyone's vote. It really was quite black and white.

I think we are now entering an area of grey. That makes our role as legislators even more important because members have on the record said, 'Look, if it goes through like it is, the Victorian model, then I can live with that and I think that will work.' If amendments start messing with that too much, then maybe their support will be lost. I think it will be important to us if amendments are moved. There are probably some things that cause no great harm or great difficulty and are just minor clarifications that do not upset the overall scheme.

Sure, that might work, but I think what we would find is if there were too many substantial amendments—and a number of people have expressed contingent support—that support might evaporate, so I think that is going to be an important part of the committee stage of the debate. I would also just say that I have very much appreciated some of the experts that the Hon. Kyam Maher has brought into parliament. Roger Hunt, as always, gave evidence to the select committee. He has come into parliament twice now, and his evidence as a practitioner has been very powerful.

The Hon. Kyam Maher referred before to the idea of the greedy children who cannot wait for grandma or mum or dad to go so they can get their hands on the inheritance, but those at the coalface, those who are dealing with people dying on a daily basis, say to us that, far from coercion, it is in fact the opposite and that people are not willing to let their loved ones go. They want them to live as long as possible. But then, as we have heard from a number of members, they do not want them to suffer needlessly in those final stages.

That is the dilemma: we do not want to let our loved ones go, but we do not want them to suffer. That is probably as good a summary as I can think of for why we are doing this bill. For most people, palliative care will be how they end their lives, with professional medical treatment. Most people do want to live as long as they can, but there are some hard cases—and we have heard about some of them in this debate—where even the palliative care experts say, 'We try as hard as we can but we cannot help everyone.' There are some people who in the final stages of their life, their suffering is intolerable to them.

I am going to pay very close attention from my retirement den, my man cave or wherever I go to retire, and I will be very keenly watching the committee stage of this debate because this is an important reform. I am very encouraged with the contributions that have been made. Even people who in the past have not voted for it are now looking a little bit more kindly, like I say, in large part because we are taking a tried and true model, and I think that is absolutely the way to go. I thank the chamber for the indulgence, for what is effectively a short second second reading speech, and I too look forward to the detailed debate in committee.

The Hon. D.G.E. HOOD: I am going to propose a way forward, which I think might be agreeable, hopefully, to the Hon. Mr Maher. It is 20 to 11 or thereabouts and we have two other matters to deal with tonight. What I propose, if he and the chamber is agreeable, and you, sir, of course, is that I have a number of questions I will simply read onto the record and he can come back in due course when we meet next and deal with those. Otherwise, we will be here for quite some time as we work our way through. Is that agreeable—

The Hon. K.J. MAHER: If anyone else has questions they want to read into the record as well that would be great.

The Hon. D.G.E. HOOD: That suits me, sir, if that is agreeable to you?

The CHAIR: Yes.

The Hon. D.G.E. HOOD: Terrific, thank you. I will do that. It will take me about five minutes to work through these, so if you just bear with me, please. Some of this does overlap a little bit with my

second reading, but I have only just given it and I have not had time to edit it, so I will do it as quickly as possible.

1. The Australian Medical Association, the American Medical Association, the British Medical Association and the World Medical Association all have a formal position against voluntary assisted dying. How can we legislate to grant the relevant authority for doctors to euthanise patients against the wishes of their peak medical body, certainly here in South Australia as well?

2. With the inequalities that currently exist in accessing best-practice palliative care, particularly for lower income families and in rural and regional South Australia, how does this legislation support improvements in palliative care access? Will it not have the opposite effect, or is it not at least possible?

3. The Washington State Department of Health commissioned a 2013 report, which I referred to in my second reading contribution, entitled Death with Dignity Act Report (number seven), where it examined the experience of that state's euthanasia laws, finding:

61 per cent of those who chose assisted suicide stated as one of their reasons for their decision their feeling that they were a burden on their family, friends and caregivers.

My question is then: how will this legislation protect individuals requesting euthanasia from feeling pressured from family and loved ones to end their life in similar circumstances to those in Washington? If it is the experience of six out of 10 individuals who requested euthanasia in Washington, why would it be different here?

4. The well-known case of Kate Cheney who lived in Oregon USA and was 85 years old when diagnosed with terminal cancer. She told her doctor she wanted assisted suicide. As I outlined in my second reading speech, she was suffering from dementia. The doctor who took the request referred her to a psychiatrist, as required by the law in Oregon. She attended the psychiatrist with her daughter and was found to be suffering from short-term memory loss.

The psychiatrist reported that Kate's daughter had shown more interest in arranging assisted suicide than had Kate, and he wrote in his report, 'She does not seem to be explicitly pushing for this'—referring to Kate. He also noted that Kate did not have 'the very high capacity required to weigh options about assisted suicide'. Subsequently, he declined to authorise the lethal prescription.

Despite Kate seeming to accept the psychiatrist's decision, her daughter did not. Kate's daughter described the guidelines protecting her mother's life as 'a roadblock to Kate's right to die' and demanded a second opinion, which was provided by a clinical psychologist who also expressed concern that Kate's decision 'may be influenced by her family's wishes'.

Despite this, the psychologist determined that Kate was sufficiently mentally competent to make the decision and she was given the necessary pills, and she took them soon after. The question is: how can it be guaranteed that exactly the same situation that I have just relayed, being a real case, will not happen here in South Australia should this bill pass?

5. Despite apparent safeguards enacted in Oregon law designed to protect patients, I cite the case of Michael Freeman, and I will do this very briefly. He requested and received a lethal prescription from his doctor a few months after being diagnosed with lung cancer. Over a year after receiving the first prescription, Mr Freeman was admitted to a psychiatric treatment facility with depression and suicidal intent. He was treated and he did improve.

Physicians for Compassionate Care volunteers helped him through his last several months of life and assisted him in reconciling with his estranged daughter. He died naturally and comfortably nearly two years after receiving his first lethal prescription. How does this bill protect against such cases where people do not meet the criteria for assisted suicide and may in fact be euthanised anyway? How does this bill prevent that happening here in South Australia?

6. Another case in Oregon involved Helen, who asked her physician for a lethal prescription. She had a history of breast cancer and was enrolled to have appropriate end-of-life care. She had been using a wheelchair for two weeks and had some shortness of breath for which she used oxygen, but she had no pain and was still doing aerobic exercises regularly. Her physician, I think appropriately, declined her request.

Helen responded by consulting a second and he also declined the request, citing depression as a cause for his decision. Following the refusal of both doctors, her husband called an assisted suicide group called Compassion in Dying who subsequently found a physician willing to write the prescription. He admitted he was shaken by Helen's eagerness to die. Again, how can this legislation protect people like Helen here in South Australia?

7. Since the Netherlands legalised assisting dying in 2002, there has been a constant increase in uptake—that is, in terms of numbers—and a shift from seeing euthanasia as a last resort to a so-called good death, as one of the doctors there has called it. Proof of this can be seen by the announcement made by the Dutch government that they intend to legislate to allow those who feel they have 'completed life' to qualify for voluntary euthanasia.

As I said in my second reading speech, this is a new concept in international euthanasia law. My question is: how does this bill ensure that the legislation will remain narrow and be targeted specifically at the terminally ill? How will it protect those in that situation here in South Australia?

8. In the short-lived Northern Territory experience, there were four patients mentioned in a follow-up report who had a low or controlled level of pain, yet their requests for euthanasia were accepted. It is apparent that in two separate cases mentioned in the follow-up report there were symptoms of depression reported in those accepted for euthanasia but no referral to a specialist psychiatrist occurred. The same scenario is possible, I believe, in the bill before us, so where is the protection in this bill to protect people in those sorts of circumstances?

9. Why is the question of mental incompetence not addressed in this bill? How can we be sure that individuals are mentally competent to decide that death is their best option? For example, *The Daily Telegraph* reported that in the Netherlands the number of people who have ended their lives due to 'insufferable mental illness' has risen dramatically from just two individuals in 2010 to 56 in 2015. What in this bill prevents exactly that happening here in South Australia?

10. How does this bill avoid the international experience where euthanasia laws are initially narrow when passed but do broaden over time? Belgium is a case in point where the number of reported cases of assisted suicide rose by 89 per cent, as I outlined in my second reading speech, in just four years, from 953 in 2010 to 1,807 in 2013. That is nearly 2 per cent of all deaths in that country being the result of voluntary euthanasia. What in this bill prevents the bill from expanding and keeps it, as has been suggested to us, in a narrower focus?

11. The World Health Organization states that palliative care affirms life and regards dying as a normal process. When palliative care of the highest quality is made available to every patient, it improves the chances of pain being managed and reduces the need for euthanasia. How does this bill ensure that by shifting the focus from palliative care to euthanasia, or by even allowing it, the quality of palliative care will not diminish? I have quoted some statistics in my second reading speech that suggest that is already happening in Victoria, potentially, and it is only 18 months or so into their bill being an act.

12. How does this bill prevent health systems from becoming geared towards providing the most cost-effective way to deal with dying patients, which will almost always be to euthanise them? Palliative Care Victoria examined palliative care funding in that state after euthanasia laws were passed and reported a decline of 6.3 per cent, after adjusting for cost increases, in the funding for palliative care patients. How do we prevent that happening in South Australia should this bill pass?

13. The Dutch government has recently announced it will move forward with plans to legalise euthanasia for children under the age of 12 as euthanasia becomes an increasingly popular, if that is the right word to use, option in that country. The bill we are debating sets a minimum age of 18, but how confident can we be that the so-called slippery slope will not see the eventual euthanising of children in this state? Even the suggestion to young children that dying is the right option is going to be disturbing or provoke anxiety and is something I personally would find unacceptable. What in this bill prevents exactly that happening, or what would the member say is able to prevent that happening?

14. A Dutch general practitioner was subject to legal action for not approving the euthanasia of a 19-year-old woman. The tragic events surrounding the suicide of Milou de Moor, who suffered from an autoimmune disease, saw that teenager suffering from severe psychological effects. She was subject to depression, mood swings, anger and blackouts. She requested euthanasia, apparently with the support of her mother, father and twin sister, but she was a teenager with severe emotional problems in addition to an intractable disease. Does that make her a good judge of her own future in those circumstances?

Perhaps Milou's doctor thought that better medication, better doctors and a more upbeat atmosphere in her family would change her outlook completely; in fact, that is what was suggested. Any patient can claim to be in the grip of unbearable suffering, which is all that this bill requires for the euthanasia process to commence. If doctors are to be sued, censured or pressured for accessing the option of euthanasia as appropriate, what is to stop doctors from just rubberstamping? I do not use that word lightly. What is to stop them from seeing that almost as the default option if they are sued for not doing it, as Milou de Moor's doctor was in Holland? What in this bill prevents that happening, or what would the member suggest might prevent that happening?

15. How confident can we be that legislating to kill even those as young as 18 is really the best option? Is the member comfortable with 18 being the right age, given the caveats I gave in my second reading speech, understanding that that is generally when we regard someone as an adult in our society? With new and life-saving drugs and medical techniques becoming available all the time, an 18 year old who is euthanised today will have no chance to benefit from the next medical breakthrough, which might have appeared when they were in their 20s or 30s, that potentially could have treated and cured their illness. What in this bill, if anything, can be pointed to to protect particularly the young from succumbing to these issues?

The Hon. C.M. SCRIVEN: I have a couple of questions. The first couple can simply be placed on the record. I just want to clarify with the mover the procedure. My understanding is that we can place some questions on the record now, we will report progress during clause 1, then the mover will come back with the answers for the continuation of clause 1 in the next sitting week; is that the correct understanding?

The Hon. K.J. MAHER: Yes. I can confirm that what I think the Hon. Dennis Hood and I have both spoken about is that the intention is, rather than going into great detail on clause 1 now, if people have questions about how the scheme operates generally, which is traditionally the area for clause 1, place them on the record now. When we come back, having the benefit of having the time to get concise answers, we can answer those, then move to the vote on clause 1, then move through the bill into its clauses.

He will tell me if I am wrong, but I think I can see the Hon. Dennis Hood nodding, indicating that. The idea is if you have questions on the general operation of the scheme, now is the time. Put them on the record. We will answer them, then very quickly vote on clause 1, then look at the operation of the scheme specifically as we move through the clauses.

The Hon. C.M. SCRIVEN: Thank you. So we will be voting on clause 1 on the next sitting Wednesday.

The Hon. K.J. MAHER: Very quickly.

The Hon. C.M. SCRIVEN: Very quickly, as the honourable member has said; thank you.

The Hon. K.J. MAHER: We were trying to do it collegially.

The Hon. C.M. SCRIVEN: Yes, I just wanted to clarify that I have the correct understanding. The first question to put on the record is: the bill establishes the voluntary assisted dying review board; can we get an indication of what resources will be provided for the board to do their duty? The second question is that the coordinating medical practitioner, and I think indeed the second also, must not commence first assessment unless they have completed approved assessment training. Could we have an indication of what would be involved in that assessment training, including things such as the duration and likely content?

For the third question, which is my final question tonight, I am hoping for a short answer from the mover because it may affect whether or not I move an amendment. In the provision regarding information to be provided by the coordinating medical practitioner to the person expressing an interest in voluntary assisted dying it includes a number of things, a list of things. It includes palliative care options; however, it does not include information about advance care directives. My question to the mover is: I thought that might simply be because this is essentially a carbon copy of the Victorian legislation, and in Victoria they do not have the advance care directive legislation that we have here, or was it deliberately and specifically excluded? If so, why?

The Hon. K.J. MAHER: I have to take that on notice and maybe come back next week with an answer to that so that the honourable member can decide whether an amendment is to be drafted.

The Hon. C.M. SCRIVEN: Just to clarify, the member will contact us directly, given that next week is not a sitting week.

The Hon. K.J. MAHER: Yes. I will get back to the honourable member out of session, effectively, next week.

The CHAIR: Other questions or information that members may seek should be asked now.

The Hon. C. BONAROS: One of the issues that we have discussed, and I think the Minister for Health and Wellbeing has pointed out, is having a clear delineation between palliative care and voluntary assisted dying and potentially some amendments that could assist in that. Could we clarify with the minister what those amendments would actually look like—not now but on the record—if they were to be dealt with in regulation or in amendments? In the delineation between palliative care and voluntary assisted dying, if there were to be amendments what sorts of things do we anticipate they would canvass? I assume definitions is one.

The Hon. S.G. WADE: I did not hear all the honourable member's comments, but I certainly intend to introduce amendments that preserve what I would call, in crude terms, the double effect laws. I think we need clarity in South Australian law as to when somebody is using palliative care to ease the pain of somebody in their palliative phase. There is significant confusion as to whether or not that is euthanasia. I do not believe it is.

I think a number of people have spoken favourably on the observations of Dr Chris Moy, the President of the Australian Medical Association. I think that it is important, in considering voluntary assisted dying legislation, that we do not undermine the very strong legislation we have on palliative care. I am sorry if I missed part of the honourable member's comments, but I am more than happy to clarify. Like any other member, I am keen to foreshadow any potential amendments. I certainly concur with the Hon. Dennis Hood's remark that now is the time to put questions on notice so that the Hon. Kyam Maher can consider substantive issues so that we can progress the committee stage expeditiously.

The Hon. C.M. SCRIVEN: That has reminded me of another question I had and it is around process. In the event that members have any questions that they would like to put to the Hon. Kyam Maher

out of session, is there a mechanism where they can be responded to on the record of clause 1? I am sorry, I am not familiar with that process.

The Hon. K.J. MAHER: Absolutely. If there are clause 1 questions that members did not have written down here that they wish to be put on the record or answered—and I am sure there may be a few of them—I am more than happy if members email them to me in the next fortnight so that it is not at the end of the month of April that we have off but by mid-April. If members wish to email them to me, I can undertake to respond to them at clause 1. I think that is a sensible way to go. I think we are all keen to try to get this finished up on 5 May. If questions are emailed through, concise answers that satisfy the questions can be given then.

The Hon. D.G.E. HOOD: Just very quickly, I think that is a very generous and appropriate approach by the Hon. Mr Maher. I can say in no attempt to filibuster whatsoever—I do not think any of us have done that in this debate—there may be some legitimate questions that come up closer to the time but I would not imagine there would many of those, frankly. I think the approach that has been proposed seems like a good way forward to me.

Progress reported; committee to sit again.