Criminal Law Consolidation (Medical Defences—End Of Life Arrangements) Amendment Bill

Second Reading Speeches

Contents

Criminal Law Consolidation (Medical Defences—End Of Life Arrangements) Amendment Bill

Second Reading Speeches

March 10 2011

The Hon. S.W. KEY (Ashford) (10:32): Obtained leave and introduced a bill for an act to amend the Criminal Law Consolidation Act 1935. Read a first time.

The Hon. S.W. KEY (Ashford) (10:33): I move:

That this bill be now read a second time.

This bill, the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill, seeks to amend the Criminal Law Consolidation Act 1935. The aim is to insert a new section in the act that addresses criminal liability in relation to end-of-life arrangements; this is when a treating doctor, at a patient's request, ends that person's life. The new section provides a defence for that doctor if they are charged with criminal offences arising out of the ending, or intended ending, of the life of that patient. The patient, or 'prescribed person', is an adult person of sound mind who is suffering from an illness, injury or medical condition that irreversibly impairs that person's quality of life so that the life has become intolerable to that person.

In this bill, 'medical practitioner' means a person, other than a medical student, registered under the Health Practitioner Regulation National Law to practise in the medical profession. A 'treating practitioner' of a prescribed person is the medical practitioner treating that person for their irreversible illness, injury or medical condition, or a medical practitioner currently responsible for the primary care of the prescribed person. As part of their defence, a doctor, if charged, would need to provide proof that the person asked the doctor to end their life and that, in those exceptional circumstances, that was a reasonable response to the suffering of the person. Here it will be expected that the palliative care measures had not effectively reduced the person's suffering to an acceptable level to that person.

A similar defence is conferred to the charge of aiding, abetting or counselling suicide, or attempted suicide, of a prescribed person by the treating doctor. The bill also provides a defence for those persons—for example, nurses—who provide support and assistance to the medical practitioner or the treating doctor who ends, or intends to end, the person's life. I believe it is important that these workers also have a defence. There is also a provision for an assistant to have a defence, even if the doctor is convicted of an offence. This is because the assistant, acting in good faith and in the ordinary course of their duties, is not expected to be responsible for the doctor's conduct.

I need to clarify what I mean by the intention of ending one's life. The intention of ending the prescribed person's life in this context provides a defence to the fact that, for some reason, the death does not ensue from the administration of drugs by the treating doctor or the primary medical practitioner. I believe that this bill is relevant to the Australian Medical Association's (AMA) statement of values, where it states:

- Promote and advance ethical behaviour by the medical profession and protect the integrity and independence of the doctor/patient relationship

Further, I am advised that the AMA Position Statement on the Role of the Medical Practitioner in End of Life Care—2007 states:

10.3 All patients have a right to receive relief from pain and suffering, even where that may shorten their life.

10.4 While for most patients in the terminal stage of an illness, pain and other causes of suffering can be alleviated, there are some instances where satisfactory relief of suffering cannot be achieved.

It is important to note that this bill does not decriminalise murder, manslaughter or assisting someone to commit suicide, nor is it a bill that supports voluntary euthanasia. Voluntary euthanasia, as we know, is not allowed under the Criminal Law Consolidation Act, and we do not have laws in this state that support voluntary euthanasia.

What this bill does is provide a defence for persons—treating doctors and medical practitioners and their assistants—providing primary care to a prescribed person should they be charged with hastening or bringing about the death, or intending to do so, of a patient suffering at the end of their life. I seek leave to have the second reading explanation inserted in *Hansard* without my reading it.

Leave granted.

The Bill inserts new section 13B into Part 3 Division 1 of the Criminal Law Consolidation Act 1935 (that being the Division dealing with homicide). In short the new section recognises that the ending of a patient's life by a doctor is, in certain limited circumstances, a course of conduct acceptable to the community.

The new section does this by providing defences for certain persons charged with criminal offences arising out of the ending, or intended ending, of the life of an adult person of sound mind who is suffering from an illness, injury or medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person (in the Bill called a 'qualifying illness'). It is worth noting that the proposed section does not exempt voluntary euthanasia from the operation of the CLCA, rather it provides a defence to offences against the homicide Division and associated offences, requiring a defendant to prove certain matters in a court before he or she is acquitted of the offence. In making out a defence under the section, the defendant is required to prove matters on the balance of probabilities; this is consistent with the evidentiary standards applying to such defences generally.

In other words, new section 13B is not a scheme that provides for a positive right to access voluntary euthanasia, nor does it otherwise legalise or decriminalise voluntary euthanasia.

Subsection (1) deals with a defendant who was the doctor who actually administered drugs to a person so as to end their life. To make out the defence conferred under the subsection, the defendant must first prove that he or she was the person's treating practitioner (a term defined in subsection (7)). This requirement ensures that the doctor patient relationship exists outside of the voluntary euthanasia context; ie, the person cannot just approach any doctor and request that the doctor administer euthanasia to them. The doctor must be treating the person for the qualifying illness etc. Second, the defendant must prove that the patient was in fact an adult person of sound mind who is suffering from a qualifying illness. Third, the defendant must prove to the court that the person expressly requested that the doctor administer the drugs bringing about his or her death. To meet their obligation, the doctor will need to produce evidence of that fact, which will necessitate good record keeping practices on the doctor's part; however, the section does not prescribe what form such evidence must take. Finally, the defendant must prove to the court that ending the patient's life was, in the circumstances, a reasonable response to the suffering of the person.

Whilst what is a reasonable response is ultimately a question of fact for the court to determine on the particular facts of the case, the Bill (in subsection (5)) offers some assistance with a statement that Parliament intends that bringing about the end of a person's life who is suffering from a qualifying illness is, in exceptional circumstances (and in particular where palliative care measures have not effectively reduced the person's suffering to an acceptable level) a reasonable response to their suffering. Having made out the elements of the defence, the court would be entitled to acquit the defendant.

Subsection (2) confers a similar defence to charge of aiding, abetting or counselling suicide or attempted suicide of a person. The main difference between the two subsections is that aiding etc. covers an indeterminate range of conduct, and hence is cast in more general terms. However, the defendant (who again is the treating practitioner of the prescribed person) will still need to prove the specified elements before he or she can make out their defence.

Subsection (3) operates to provide a defence to those persons (e.g. nurses and hospital administration staff) who could be charged with an offence that consists of assisting the doctor to end a person's life. That is, it is generally an offence to help someone else to commit an offence, and because this section provides defences, rather than exemptions, it is still possible to charge such an assistant with an offence. That would result in an obvious injustice if the doctor who ends the life of a person suffering from a qualifying illness can avail themselves of a defence, but the nurse who hands

him or her the syringe could not. So, paragraph (a) provides that if the doctor is acquitted of an offence, so the assistant will be. However, paragraph (b) allows an assistant a defence even where the doctor is convicted of an offence. This is because the assistant, acting in good faith in the ordinary course of his or her duties, should not be expected to be responsible for the doctor's conduct. If the defendant wishes to use the defence in paragraph (b), however, he or she must prove that his or her conduct was in fact done in good faith and in the ordinary course of his or her duties, and that ending the patient's life was a reasonable response to his or her suffering.

Subsection (6) extends the effect of the defence: if a person is acquitted (having made out a defence under the section) then he or she incurs no civil liability, including in disciplinary proceedings, in relation to the conduct forming the basis of the offence with which they were charged provided the conduct was done in good faith and without negligence. However, should the conduct have been negligent, an injured party will still be able to bring proceedings to recover their loss, even if the defendant was acquitted. The subsection also allows a court that acquits a defendant to make ancillary orders if necessary to cover unforeseen effects of the defendant having been charged.

Debate adjourned on motion of Dr McFetridge.

March 24 2011

Adjourned debate on second reading.

(Continued from 10 March 2011.)

Dr McFETRIDGE (Morphett) (11:18): I rise to support this bill introduced by the member for Ashford (Hon. Stephanie Key) The member for Ashford has been a very strong supporter of voluntary euthanasia in South Australia, but I should point out from the very start that this bill is not about voluntary euthanasia per se, as in the other bills before the house or what people would perceive to be a voluntary euthanasia piece of legislation.

The bill before us is the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011. The bill amends the criminal law to insert a defence for bringing about the death of a person if it is requested by that person. The prescribed person, who will be a medical practitioner in all cases, as I understand this legislation, will be a doctor who is the regular treating practitioner of the person involved. They will have as a defence for their actions this legislation. It would be a shame if people who want to die with dignity are not able to do so. We have seen a number of pieces of voluntary euthanasia legislation come to this and the other place only to be either continually adjourned or voted down, in many cases, by the narrowest of margins.

As the Liberal member for Morphett, can I say that, when we survey my constituents on the issue of voluntary euthanasia, over 75 per cent of the respondents of all backgrounds (some professing to be extremely strong Christians, others have secular backgrounds, atheists) are pro-choice, and that is what this legislation is supporting—people's right to make a choice about their future.

If part of that decision about their future involves their medical practitioner giving them treatment that results in their life being ended, that medical practitioner will have a defence within the criminal law. It is an interesting piece of legislation. Some issues have been raised by a number of organisations about words such as 'intended' and about the numbers of people who are 'prescribed persons' in the legislation who can use this as a defence.

It is a piece of very important legislation. I think that, anecdotally, the evidence is there that medical practitioners have been doing what I see as a compassionate act, that is, ending people's lives in a way that enables those people to die with dignity, and it is just so important that that happens. As a veterinarian, I have had access to gallons and gallons of drugs that can end the lives of not only animals but people.

I have had requests from people who have been dying of cancer: 'Can I have a bottle of nembutal,' because nembutal is the one that is always talked about. I have had requests for other drugs that I have had in my possession, and I have never done that. Look, I will be honest, I have been very tempted. When my father died of bowel cancer, fortunately, dad did have very good palliative care and he was able to have a death that was peaceful and dignified and we were able to be with him at that time.

However, had he been a case where palliative care was not working, I would have been in a very difficult position because I would not have wanted my dad to die in agony, in pain and in suffering—a prolonged death, an undignified death—because I knew what sort of person he was. He was a man of dignity. He had great pride. I knew that, even at the end, having to be cared for the way he was had a deep effect on him; it had a deep effect on us as his family.

I have very close friends who have had severe cancers, and they have been cancers that have rapidly progressed. They have been extremely debilitating and, in many cases, extremely painful. I have had those people ask me for drugs and I have had to refuse. It has been hurtful, because I do know—and I do not want anyone even to think for a moment that I am in any way comparing the death of a human with the death of an animal—that, in my veterinary practice over many years, and having to euthanise many, many animals, it is a good thing that we do.

It is a good thing when you make that decision, although animals do not have that choice. As an experienced vet, you know that animals do recognise, they do know when their time is up, and we are able to assist them to die swiftly and, I should say, with dignity, because animals do not like being mistreated. To be able to do this with humans (and I am not comparing the same event; please do not draw that at all from what I am saying), to be able to enable people to die with dignity, is just

something that I strongly am committed to. This piece of legislation goes a long way towards that being able to happen.

For doctors around Australia, and internationally, who are assisting their patients—and it has to be long-term patients; it cannot be somebody you have just been acquainted with—to die with dignity and not have to suffer the repercussions and accusations of having committed a criminal offence, this legislation will go a long way towards solving the issue.

The legislation was put together with the assistance of the Minister for Health, the Hon. John Hill, and I thank him and his staff for that. Certainly, the parliamentary counsel, Mr Mark Herbst, has given us a lot of good advice on this legislation.

I have consulted a number of lawyers, friends of mine, about this. The only issue that was raised with me by one of my legal friends, who is a very experienced lawyer and has numbers of case law on his record, was that if there was a charge proceeded with against a doctor, who would pay the cost? Under normal criminal law, the costs are not covered by the Crown. The intent here is to provide a defence. If there is ever a case where a doctor does have to defend his actions under this piece of legislation, that could be costly. I would like to see this issue addressed at some stage.

Other than that, I do not have any issues with this piece of legislation. I think it is a good move. We do know that there are many doctors at the moment who are assisting their patients to have a dignified death. I hope this does give them some comfort, and other doctors who would like to be able to act in this way, to give them some courage to be able to act in this way.

It is such an important thing that we allow people to have dignity throughout their lives, but particularly when they are at their most vulnerable and when they are on their deathbed. I commend the bill to the house, and I look forward to the support of members. I should say that, while I am the shadow minister for health, the Liberal member for Morphett, this is a conscience vote. It is a conscience vote for the Liberal Party, and I know that some of my colleagues may not agree with my views. I am yet to convince them of the merits of this, but I will not give up, because I know without any doubt whatsoever that this is the correct thing to do. With that, I commend the bill to the house.

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for Mental Health and Substance Abuse, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (11:27): To pick up a point made by the member for Morphett, this is a conscience vote, and what I say today, of course, is my personal view, not that of the health department or the government, so I make that plain. I do congratulate the members for Ashford and Morphett for sponsoring this piece of legislation.

What I want to do today is three things: first, explain my own view about end of life and my personal view about the questions around euthanasia; secondly, say why I did not support the previous legislation that was brought before the house in relation to euthanasia; and, thirdly, why I do support this. Personally, in an abstract sense, I support the notion of euthanasia. Without thinking about it deeply, that used to be my position, and I would have probably supported any legislation along those lines.

Ten or 11 years ago my sister died of cancer, and I saw the progress of her death over a period of time. I know all of us have these anecdotes and I do not want to be weepy or sentimental about it; it just instructed me about end of life stuff. She was only relatively young; she was 47, and she fought the whole disease all the way through. She was convinced she was going to survive, but it was clear to her medical team that she was not. She just did not do the things that she ought to have done in anticipation of death, and I think it was because of her age. At 47 she did not want to die so she did not properly embrace the palliative care.

When I arrived in Sydney (where she lived) a week before she died, she had been admitted to hospital and she was in awful pain and agony, and they were giving her shots of morphine on a regular basis. I stayed with her pretty well the whole time. You could see the morphine kick in and relax her, and at the end of the period the morphine would wear off and you could see the agony. I thought this was dreadful, somebody should get in there and shoot her—that was my feeling; I thought it was cruel, inhumane, horrible—and I would have done it myself.

However, after a day or two a palliative care doctor came along and properly provided the drugs that she required. As a result of that, she went into, over a period of time, a deep coma. There was a pump on, there was no up-and-down change in the pain that she was feeling, and she went into this

slow decline. I knew exactly what was happening and how long it would take, virtually, and the doctor was very good at comforting those around her and explaining what was happening; so, we saw her dying.

One of the advantages of this, I think, was that family and friends were able to spend time with her, at her bedside, in the last few days of her life and were able to say their goodbyes. Her children were able to be with her and say their goodbyes; my mother was able to say her goodbyes. A bit of a party atmosphere actually developed around her bedside over the course of the four or five days, and I thought that was pretty good. I thought it was actually a really good thing.

So, I have different views now about euthanasia as a result of that because, if we had applied that principle early on, that last four or five days of saying farewell and kind of getting used to the idea would not have occurred. So, I do have very mixed views about it.

The Hon. R.B. SUCH: I move:

That the house extend the time by 10 minutes to allow the minister to complete his remarks.

Motion carried.

The Hon. J.D. HILL: Thank you very much. I recognise this is private members' time, so I appreciate the courtesy you have shown me. I had different views. I no longer had that sort of black-and-white view that I had in the abstract before I experienced somebody dying and the process of palliative care. That is what I want to say: my views are complicated; they are not simple. It is not black and white for me any longer. However, I recognise that many people do want to be able to exercise some sort of right to terminate their lives under certain circumstances.

Every time a member of parliament or a community group has tried to codify euthanasia, I think they have come up with the same problems. It becomes overly complex and very bureaucratic, and it creates a state apparatus which, to me, is the opposite of what you really want at the end of your life.

I have a number of objections to the proposals that have been put forward. It is a very complicated bureaucratic process; it would take a couple of doctors to agree, and they would do that over a long period of time, so the benefits that might accrue to a quick decision would be lost. You would always find, I think, a couple of doctors who would be prepared to rubber-stamp any applications, so the safety checks would not really apply. I was concerned about it being made part of the palliative care legislation because I think palliative care is really important, and to pollute the notion of palliative care with a reference to euthanasia, I think, would make people fearful of palliative care.

My third objection is to the establishment of a state mechanism which would be appointed by the health minister and which would be responsible to the health minister. I thought that created complications as well. However, I think the proposition that is now being put forward addresses all of those central issues.

What is being proposed does not establish a right to euthanasia. What it does is establish the right for the doctor-patient relationship to be used to decide what is in the best interests of the patient in particular circumstances, and that includes the use of medication to produce death in the circumstances which the bill outlines. I think that is the right way to go. I think we should make the doctor-patient relationship the heart of what we are doing in this area, because I think in that relationship, where the doctor knows the patient and the patient knows the doctor, we will get, in nearly all of the circumstances, good decisions. You cannot go shopping around for a doctor who might be a bit gung ho or maverick in their attitudes or in their practices; it has to be in the relationship that pre-exists, and I think that is a really important thing.

The second point about this is that it does not provide a set of rules and guidelines and boxes that you have to tick before you can access this—it is not a right—kind of care. It is about what is in the best interests of the patient according to what is reasonable in the circumstances, and what is reasonable in the circumstances can be tested by the courts.

The test of reasonableness, as lawyers would know, is not a subjective test. It is not what the doctor or the patient thinks is reasonable, it is what the man in the Clapham bus (to use that British legal cliché) thinks. It is an objective test: what an outsider looking in would say was reasonable in the circumstances, so the law would be able to determine whether the use of this power was done appropriately. We do not codify it in a detailed way; we allow the law to supervise it. I think that is a very strong safeguard against abuse. The fact that both the doctor-patient relationship and the legal processes oversee it creates a sufficient number of safeguards.

My final point is that I did consult with the AMA over this legislation and received some advice, some of which was incorporated into the provision. The AMA has told me in writing that it does not object to this legislation. I think it is a very good thing to have the doctors' organisation onside, because we know that, if that conservative organisation supports it, it is not a dangerous or radical provision. This is one very small step forward. I am sure the Euthanasia Society and many other organisations will be bitterly disappointed that it does not go to where they want to go which is to give people an absolute right. I think that would be going too far and the means of achieving what they want would not be supported by the medical profession nor many in the community.

This takes the provisions one step, which allows the doctor-patient relationship to determine what should happen in the circumstances that the legislation provides within a legal framework, with the common law really settling over time what essentially can happen. I commend this to the house and I thank the member for Ashford and the member for Morphett for bravely moving and seconding it and speaking in favour of it in this chamber.

Mrs GERAGHTY: I move:

Private Members Business, Orders of the Day, No. 3, have priority over Private Members Business, Other Motions.

Motion carried.

The Hon. R.B. SUCH (Fisher) (11:37): I will be brief because I want to see this matter progressed. I support this measure. As members know, I have standing in my name a bill which I obviously intend to put if the situation arises. This measure deserves support because, as we now know, doctors essentially are ending the lives of patients, so it is already happening, and I think it is important that we address what can be a grey area in relation to ending someone's life. I do not believe that doctors will inappropriately seek to end a life. Doctors commit themselves (in their work as doctors) to upholding the sanctity of life so I do not believe that this measure would be used inappropriately.

The reality is that there is a deficiency at the moment for a number of people who cannot get adequate pain relief. I think of people like the late president of the upper house (Gordon Bruce), a lovely man, who died a shocking, agonising death from motor neurone. He used to ask people visiting him, I am told, to basically help end his life. We should not have people in that situation.

This bill will allow a medical practitioner, using their normal standards of medical care, to ensure that a person does not suffer and that their life is ended with dignity. I agree with what the Minister for Health said: the other options are more complex and more complicated but this is a very simple proposal which basically allows a medical practitioner to end a life with dignity. It is already happening every day in Adelaide at the moment, so let us move to clarify it and provide some clear direction in relation to what should be a dignified end of life for a person. I support this measure.

The Hon. S.W. KEY (Ashford) (11:39): I would like to thank the house for allowing us time to deal with this bill. In addition, I would like to thank the speakers who have supported the bill, which is a medical defence for end of life arrangements and amends the Criminal Law Consolidation Act. In amending that act, this does not say that euthanasia is legal. It does not say that murder, manslaughter or assisting someone to suicide is legal. What it does do is provide a defence should a medical practitioner or treating doctor (as defined in the bill) be charged with any of those crimes. It does not take away from the fact—

Members interjecting:

The SPEAKER: Order! This is quite an emotional thing for some members. Could we show some respect, please, in the debate?

The Hon. S.W. KEY: It is important to stress that this bill does not take away from the very good work that happens in South Australia with regard to palliative care. I have the highest respect, and I know all the speakers who have contributed to this bill also have that respect for the palliative care provisions that are available. What we are talking about is providing a defence to a medical practitioner or treating doctor should they be charged with any of those offences that I have mentioned.

The focus for me in the voluntary euthanasia debate has been very similar to the member for Fisher and the member for Morphett. We have argued a number of times that people should have the choice of how they end their days. They should be able to die in dignity. I will continue to campaign on that

basis, as I am sure other members in here who support that choice will do. It is also important, I think, to take up minister Hill's suggestion that we need this first step that provides a legal defence for medical practitioners.

My main focus in this campaign has been to make sure that people have access to information for a whole lot of end of life decisions. Part of my campaign, as with other members in this house, has been that advance directives are available and made more simple. So, another part of the campaign that I think will continue is that we bring in legislation that looks at making it easier. Members here will particularly know what it is like for family, friends and constituents to try to get through the maze of not so much wills—that is an issue in itself—but certainly the medical power of attorney, decisions on organ and tissue donation and so on.

So, this bill is very specifically directed at providing a legal defence to doctors should they and their patient decide that their end of life needs to be triggered. It is a very simple piece of legislation but also very sensitive and important. I ask members to consider the fact that this does not decriminalise euthanasia. It does not change the Criminal Law Consolidation Act to say that murder, manslaughter or assisting someone with suicide is not a crime. It is just that, if a doctor and their patient do come to that arrangement, there is a legal defence for that medical practitioner and treating doctor should they be charged.

Bill read a second time.

In committee.

Clause 1.

Ms CHAPMAN: Point of order, Madam Acting Chair. The time for dealing with—

The ACTING CHAIR (Mrs Geraghty): That is all right. If you would like to take your seat, we will be one second.

Progress reported; committee to sit again.

Ms CHAPMAN: Madam Speaker, I now make a further point of order. The motion to extend time has now expired according to the clock and the house may receive a further motion to extend time, bearing in mind that we are now into the second part of private members' business for which speakers are here ready to deal with their items of business. If a further motion is to be put, I think the house needs to make a decision about whether we are going to deal with this issue.

An honourable member interjecting:

Ms CHAPMAN: I keep hearing that, but we have—

The SPEAKER: Member for Bragg, I think you probably were not present, but the time that expired was actually time for the member to speak, not the time allowed for the bill. We had already agreed to extend the time to get to that stage that we have just got to with the bill. I think we are now ready to move on.

Ms CHAPMAN: If the motion was put that we simply speak to continue the bill for whatever anticipated time without a time limit—that is not what I heard—but my understanding is, just so that we have it clear—

An honourable member interjecting:

The SPEAKER: Order!

Ms CHAPMAN: Just so that we have it clear, the minister was given the opportunity by motion to conclude his remarks. A second motion was then received for 10 minutes to enable the member for Fisher to speak and, as I understand it, conclude the debate. The 10 minutes has expired, and I simply raise the point that we are now past that motion period. If my understanding is that, having got to the committee stage, the debate is now going to be adjourned, I will not take the matter further. However, I want that on the record.

The SPEAKER: You have made your point of order, member for Bragg, but there actually was no time limit on the extension of time that we agreed. We agreed to extend the time until the business was finished, which is what we did.

May 5 2011

Mr WILLIAMS (MacKillop—Deputy Leader of the Opposition) (10:42): I move:

That standing orders be so far suspended as to enable me to move a motion without notice for the rescission of a vote of this house on this bill forthwith.

The SPEAKER: I have counted the house and, as an absolute majority of members is not present, ring the bells.

An absolute majority of the whole number of members being present:

Motion carried.

Mr WILLIAMS (MacKillop—Deputy Leader of the Opposition) (10:44): I move:

That the vote on the second reading of the bill be rescinded.

Motion carried.

Second reading.

Mr HAMILTON-SMITH (Waite) (10:45): I rise to speak on this bill with a heavy heart because I can well imagine circumstances where the terminally ill would seek relief and circumstances in which they would seek assisted suicide as a pathway from their pain. I think every member of the house can envisage circumstances—and many will have been personally engaged with those circumstances—where, as an act of compassion, one might wish upon a loved one a passing, if only to relieve them of their agony and suffering.

The Hon. R.B. SUCH: Madam Speaker, can I just seek—

The SPEAKER: Order! Is this a point of order?

The Hon. R.B. SUCH: Point of order. Can I seek a clarification? Given the process that has happened, can people who spoke before in the second reading speak again?

The SPEAKER: No, that is not possible. We have gone back to the second reading stage, but if you have spoken that is it.

Mr HAMILTON-SMITH: Having said that, I signal that I will be opposing the bill because I think it opens a Pandora's box. I have spoken on this matter in regard to an earlier bill on 17 May 2001. I do not want to repeat the arguments I raised on that occasion, but I will make a few points. Firstly, I draw the house's attention to the declaration on euthanasia adopted by the 39th World Medical Assembly in Madrid, Spain, in October 1987, and also the 44th World Medical Assembly in Marbella, Spain, in September 1992, which stated the following—

The SPEAKER: Order, member for Waite! There is too much background noise and it is very difficult to hear the member, and this is a very serious issue, as we have taken a serious step. Can we have less noise, please.

Mr HAMILTON-SMITH: I quote:

Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.

I also draw the house's attention to references to this matter in the House of Lords, in its session of 1993-94, and the Report of the Select Committee on Medical Ethics, Volume 1—Report, page 10, and later debate within the House of Lords on the subject. I again draw the house's attention to the Australian Association for Hospice and Palliative Care and its comments on the matter that have been made in the past.

I can envisage a multitude of circumstances where one might seek assisted suicide. First, as has been pointed out during this debate, there are circumstances in which people find themselves in extreme pain and find they are undergoing extraordinary suffering with inadequate palliative care and medical relief, and they simply feel they cannot go on. This is acute and concerning and would strike at the heart of every person here.

But the bill ultimately suggests that the way out of that situation is assisted suicide. I think there are other alternatives. I think advancements have been made and that further advancements can be made in palliative care, but I think, too, that these are matters largely for families and the suffering to address, not the parliament.

A second reason why people might want to commit suicide is that they feel alone. They feel unloved, they feel unvalued, and they feel as though they are a burden on their family. They feel as though the world would be better if they were not still in it, that there is no point in going on. Again, I think these situations are best left in the hands of families.

A third situation may be that they wish to commit suicide because they feel clinically depressed. They feel that their family, as I mentioned, would be better off without them, that they have fallen into a state of complete and absolute despair and that they are putting their loved ones through a unendurable ordeal and that the world and their family would be better off without them. Again, I feel these are circumstances that are best dealt with by families and not by this parliament.

There are no right or wrong answers to this terrible question, but I would say simply this: in my own family experience, I have seen, on the one hand, suicide, and, on the other hand, a teenage cousin within a week of death from leukaemia suddenly go into remission. She is now a happy mother with two children and living a bountiful life but, had this act been passed prior to her condition reaching that extreme point, I am quite certain she would be dead. Everyone has their own stories to tell in regard to this matter.

I am also very concerned about efforts a parliament might take to codify this question of assisted suicide. I know advocates of the bill do not like the term 'suicide', but that is what we are talking about; we are talking about assisted suicide. If you codify these things you take away whatever discretion exists at present under current arrangements.

No-one is talking about turning the machines off and letting nature take its course. We are talking about active intervention, and just like a bill of rights, just like attempts to change the constitution, once you codify things if it is not in there then it is out. If it is not legalised by the law, then it is outside the law. You bog down and clog up whatever fluidity there is in arrangements between families and the medical profession at the moment to make compassionate decisions on behalf of their loved ones who are in such agony.

The other thing is that my experience as a lawmaker tells me that once you open this threshold moral issue and legalise assisted suicide and murder, you will start the path down a slippery slope. Soon people will be arguing on the basis of discrimination that their mental illness or their condition is equally painful and equally distressing as that determined by the bill at the outset, and they will be saying that they are discriminated against, that they have their right to select and opt for suicide just like the other person who is in agony. You will get into all these arguments about what does or what does not constitute a medical condition or a mental condition sufficient to require or enable legalised suicide.

It is a slippery slope. I do not know where it ends. I do not know whether it ends in Aldous Huxley's *Brave New World*, I do not know whether it ends in a place where other regimes have taken us in the past in history, where we seek to get rid of the mentally ill, the physically deformed, and those who are not fully fit and well: the Spartan ethic. I do not know where it takes us, but I do not want to start a legislative process that ends at that point.

Claims for popular support for this measure, I think, are thin. I doubt if this issue would survive a national referendum once the electorate was fully informed. I would say this: society already authorises killing. We understand that at times it is necessary for our soldiers to fight on our behalf, to fight for freedom, and to kill. We have just had Corporal Robert Smith awarded the VC and describe his acts of killing on our behalf serving his country. This parliament and other parliaments in this country already endorse murder in certain circumstances and that is one. However, it is another step to authorise legalised suicide.

I read in the paper today the story of Mr Ramazan Acar, who killed his beautiful daughter, Yazmina, with a knife for the purpose of getting even with his wife. This man is scum. I will never introduce legislation into this place to authorise the death penalty, but I hope that no-one else does because, when I read cases like this, I would be challenged to vote against a death penalty bill because I think there are circumstances where, as with our soldiers, we might authorise the taking of a life to eradicate this community of evil.

I will not be introducing a bill, and I hope that no-one else does because I do not want to have to make that terrible decision. To me, however, this is a separate issue: authorised suicide. It is a moral dilemma. I suspect many of the advocates of this would oppose the death penalty while supporting euthanasia. I understand the compassionate basis upon which this bill has been introduced, but I will be opposing it with a heavy heart.

Mr GARDNER (Morialta) (10:56): I have been thinking long and hard about this bill, as I am sure all members have. This is the third bill introduced into the parliament since my election in March last year that has sought to allow for a process under which someone in suffering may be able to access euthanasia. Whichever way any of us votes on these matters, we will disappoint as many people as we will satisfy.

I know that I will disappoint a number of people when I say that, while there may be value in exploring issues at the committee stage, I cannot see myself at this stage supporting the bill as it stands at the third reading. The focus of this contribution is to put my views on the record for the benefit of those of my constituents who might be interested. I will do so in relation to the broader issue of euthanasia as well as this specific bill.

We are obliged on matters of conscience to consider all the arguments at length, to listen to the views put to us by our constituents, as well as anyone else who takes the trouble to approach us in good faith to put their case, and we must reflect on our own principles. I would like to begin by thanking the many constituents and others who have taken the time to contact me to share their views on the matter. I have read many compelling arguments.

I am also grateful to those whom I have sought out, particularly from the medical and legal professions, as well as some of those who ply their trade in this building and others, who have been willing to give me the benefit of their expert advice and answer some of my questions.

Our core beliefs in relation to these matters cannot help but be shaped by our upbringing. I grew up in a family that placed great value on personal sovereignty, freedom of choice and scepticism of any government intrusion into one's own decisions. If euthanasia was a topic for discussion at the dinner table, there was never any question from my parents that individuals should not be forced to suffer the indignity or the pain of an intolerable death if that was not their wish.

In my late teens, I came to Christianity, or perhaps that is the wrong way round: it is better to say that I was found. I was baptised in the Lutheran Church and exposed to the argument that the immutable sanctity of human life should supersede one's personal choice about how one's own life might end. In relation to these bills, some have approached me on the basis that, because the church to whose theology I subscribe is opposed to euthanasia, I therefore should necessarily vote against any voluntary euthanasia legislation in this place.

In my maiden speech, I explained that my faith is a personal matter and that I abhor any suggestion that the government would ever seek to stop me or anyone else from practising their faith or from living life by any other principles they hold dear. In the debate on the euthanasia bill that was unsuccessful in the other chamber late last year, the Hon. Stephen Wade articulated the point well in explaining why he was not universally opposed to any such legislation, although he was voting against that particular bill for a range of reasons. He said:

> While my Christian faith teaches me that it is not an option that I should see as available to myself, in a pluralist society and as a Liberal I accept that others make other choices so, I do not rule out euthanasia being made legally available to South Australian adults...

Most members who have spoken on this issue have very appropriately shared with the house their own personal experiences that have informed the views they hold about matters to do with the end of life. I am very grateful that I have never had to, as others have, suffer the incomparable pain of losing a parent, sibling or a child. I have lost my four grandparents across the decades of my life.

Delivering the eulogy at my grandmother's funeral was a much more difficult speech than any I will ever deliver in here, and we lost my dad's dad at the beginning of last year in the weeks before the 20 March election. Grandpa was strong willed and opinionated. Some called him obstinate. He was passionate and courageous. Starting from a modest background, he worked as a policeman in England and he served in the Second World War. After the war he brought his family to Australia to build a new life in a brave young country.

He lived to what some might term the ripe old age of 95, although particularly for the last two or three years of his life he did not call it living as his body refused to cooperate with his strong mind. He

received excellent treatment for a wide range of problems. He felt little physical pain as his body deteriorated, but he suffered mental anguish of great duration. Other members of my family have agreed that he would have been pleased for me to talk about him in the context of framing my views in support of the principle of this sort of legislation.

It was barely a week after his passing that I and other candidates from Morialta who were present at the candidates forum at Campbelltown City Council were asked what our views were on the issue. As I recall, the Greens candidate expressed his firm support, and the then Labor member expressed her heartfelt opposition to any such legislation, instead arguing in a most compelling manner for a greater focus on palliative care.

At that forum I gave much the same description of my position as I am giving today. I also pointed out the importance of appropriate safeguards necessary to ensure that the legislation is not open to abuse. This sort of legislation would be much easier to deal with if there were not those in our society who are willing to act in appalling ways.

I agree with the Minister for Health, who made an excellent contribution to this debate in preferring a model that allows for a statutory defence under the criminal law rather than the more bureaucratic statutory voluntary euthanasia schemes that have also been proposed, although I do not necessarily rule them out. Minister Hill describes them as 'the establishment of a state mechanism which would be appointed by the health minister and which would be responsible to the health minister'.

But a statutory defence proposal should include significant safeguards such as would ensure that some of the nightmare scenarios that have been suggested could not take place. The law should also be clear in order to provide clarity for the courts and those who serve in them, including the juries. I am not satisfied at this stage that the bill in front of us delivers in relation to that aspect. If we reach the committee stage I will listen to the ensuing debate about those matters and any potential amendments, but this is the basis of my objection to the bill.

The bill also deals with issues of aiding and abetting, and providing support and civil liability, but in the brief time available I will focus on the guts issue: the proposed framework between doctor and patient. The bill essentially lists four safeguards in a new section 13B of the act, which reads:

> Criminal liability in relation to end of life arrangements:
>
> 1. It is a defence to a charge of an offence against this division, arising out of the death or intended death of a person, if the death resulted or was intended to result from the administration of drugs to the person by the defendant and the defendant proves, on the balance of probabilities, that:
>
> (a) the defendant was at the time of the conduct to which the charge relates, a treating practitioner of the person;
>
> (b)the defendant believed, on reasonable grounds, that the person was an adult person of sound mind who was suffering from an illness, injury or other medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person (the qualifying illness);
>
> (c) the conduct to which the charge relates occurred at the express request of the person; and
>
> (d) the conduct to which the charge relates was, in all the circumstances, a reasonable response to the suffering of the person.

The Law Society and others have expressed some serious concerns about terms like 'reasonable grounds' in paragraph (b) in relation to both the finding that the patient must be of sound mind and that life was intolerable. They also expressed concerns about the use of the term 'reasonable response' in paragraph (d)—that 'the conduct to which the charge relates was, in all the circumstances, a reasonable response to the suffering of the person'.

These are subjective terms and ones which provide too much ambiguity about the sort of process that we are proposing that the courts should allow. The bill also falls down on what is a threshold issue for me, in that it does not require that a second opinion be sought about either the diagnosis or treatment of the qualifying illness, in order to establish the irreversible impairment that is required; and nor is any psychological assessment demanded to ensure that the apparently intolerable quality of life afforded to the patient is not the result of a treatable state of depression.

Finally, there is the issue of consent. This is an issue on which I would not have thought ambiguity was an option, yet the obligations on the doctor to demonstrate that the conduct to which the charge relates occurred at the express request of the person are undefined. I imagine that these questions may be approached in the committee stage, along with many others, and I look forward to the

responses to the bill's proposals. However, as I have said, at this stage I will not be voting for this bill in this form at the third reading.

I look forward to hearing the contributions that other members have to make. I have been informed somewhat in my own deliberations by the contributions made so far. I believe they have been made in the best of spirits and I appreciate the contributions of those members.

The Hon. T.R. KENYON (Newland—Minister for Recreation, Sport and Racing, Minister for Road Safety, Minister for Veterans' Affairs, Minister Assisting the Premier with South Australia's Strategic Plan) (11:06): I welcome the opportunity to speak on this bill and I thank the members for Ashford and MacKillop for their organisation and cooperation. I will say at the very start that I have no doubt at all about the goodwill and intention of everybody involved in this debate—and the compassion of those involved in this debate. This debate is being approached from both sides by people of goodwill and good intention and compassion, and I do not have a problem with that. It will not come as a surprise to anybody at all in this house that I will be opposing the bill. I do oppose the bill and come down on that side of the bill, but I want to say very firmly at the outset that I accept the goodwill on both sides.

The first point I want to make very clearly is that this is a euthanasia bill. There has been some attempt to say that it is not, that it is a change to the criminal code and so on, which it is, but let's be quite clear that this is a euthanasia bill. A patient can ask a doctor to kill them, and that is euthanasia. So let's have the debate—we are having the debate—but let's be clear about what we are debating. We are debating euthanasia. Let's not pretend otherwise. Let's not get into semantics; let's not have a debate about dictionary definitions. This is a euthanasia bill. This is a bill allowing people, with the assistance of their doctor, to kill themselves.

If you are going to have a euthanasia bill, it seems to me that this is the very worst sort of euthanasia bill you could have because it essentially has no regulation whatsoever. The house should be quite clear: it would not matter if it came in a very well regulated euthanasia bill, I would still oppose it. But if you are going to have one, it should be well regulated. I think that is a fair point to make. You could argue very clearly that there are varying degrees of effectiveness and varying degrees of public good in different bills, and a bill that has no regulation or very little regulation is, in my opinion, going to be a lot worse than a bill that has a much greater and more rigorous regulation.

I think the problem with regulation is that it gets overly bureaucratic, you have basically a death committee who would then feel it is their duty to work out whether people can live or die, but we will get to that when we get to another bill because I am sure there will be another bill at some point. The second point I wanted to be very clear about is that this is a euthanasia bill that has almost no regulation, almost no control about it.

The doctors' defences are fairly open. There is not a lot required for them to mount their defence, so essentially it can come down to a matter of a doctor's word against someone who is not there any more. In fact, it could be the doctor's word against someone who may not have even been in the room. You come down to taking the doctor at their word that the patient was of sound mind, that they were a treating practitioner which could be, for the purposes of this, someone just saying, 'Yes, I asked him to treat me yesterday.'

The situation could arise where 'I know that doctor will give me the injection I want, therefore I asked him to treat me, therefore he is my treating practitioner.' There is not a lot of beef behind any requirements or any defence that is required. In the event that it even goes to court—which I think this bill makes a much less likely scenario—it is going to be, 'Were you the treating practitioner? Yes. Were they of a sound mind? Yes. Did they request it? Yes.' Who can dispute that? It would be a very difficult thing to do.

It should go without saying that human life is incredibly important. One of the key roles of a state—which it accepts through a number of other statutes, most notably the murder laws—is to defend and protect life and to protect the safety of people in this state. When we start introducing laws like this, it waters down the commitment of the state to protect life. That is an important point for this house to consider. Do we want to water down the role of the state in protecting life?

Many people argue that this happens anyway. In fact, I have been talking about euthanasia with a young doctor. I said, 'What worries me is that this will make it easier for doctors to kill patients so they can get the bed that they need for another patient.' He said to me, 'We do that all the time already.' That is one doctor in conversation with me. Maybe he was being a smart-arse—it would not be the

first time that I have been involved in a smart-arse conversation—but anything that makes it easier is wrong.

We have seen incidences of doctors who can be quite callous about these things. The most egregious example, of course, was Dr Death. Obviously he was out killing people. It is much easier for a prosecution to say that he was out there to kill people, because he killed so many people. You could quite possibly have someone out there—a doctor—killing patients and then saying that they asked for it, and it would be very difficult to prove otherwise. So, this is a concern. The other concern is about medical practitioners. It is probably my own ignorance of the bill but, on my reading of it, it does not need to be a medical doctor for those purposes. Does it say that?

Members interjecting:

The SPEAKER: Order! Can the speaker get back to his comments, and members on my right, please behave.

The Hon. T.R. KENYON: It was actually very useful, Madam Speaker. They clarified the point that I was about to make; it would have been erroneous. I read minister Hill's description of the death of his sister. Without dwelling on his personal circumstances too much, his argument, to me, seemed more like an argument for increased or improved palliative care. When she actually received some decent palliative care, she was much happier, much more comfortable and it was actually, in fact, a beautiful death—the so-called beautiful death that euthanasia seeks to be.

Even minister Hill himself mounted an argument for better palliative care, and I would very happily support any move for greater and better palliative care that might come before the parliament. I come back to the point that I am trying to make: this is an unregulated euthanasia bill. It is a bill that puts doctors in a position I do not think they should be in. I do not think it should be the role of doctors to kill people; it should be the role of doctors to protect life and make people comfortable.

I am comfortable with people withdrawing medication. I am comfortable with people making the decision to receive no further treatment and letting the natural processes take their course, but I am not comfortable with allowing doctors to administer a lethal dose to patients to whom I believe they have an obligation to try to improve their life and their lot. The most notable and most effective way of doing that is through palliative care.

Mrs VLAHOS (Taylor) (11:15): I had not expected to speak on this bill today but, as I will be away on the next sitting week, I will place on the record my thoughts on this topic. When I was younger and in my 20s, I took the view that euthanasia should be legalised. I have changed my views over a period of 20 years with the more life experience I have had and with both relatives passing and seeing partners' parents die slow and torturous deaths, sometimes through their own choices about medical treatment or non-medical treatment. I will share some of those today with you.

I will be opposing this bill, and the other bills before the house on this topic, for many reasons. Firstly, I trained in health administration and coded the death and cancer records of many patients as a health information manager—a record coder in both public and private hospitals in the state—before I became involved in politics and worked in this area. I saw the treatment regimes, and I have seen the changes that palliative care has effectively made to people's lives and how it has improved their experiences. Over time, palliative care has become more sophisticated, it has become more compassionate, and it has been a good thing for many families, not just the individual.

The second reason I will be opposing this bill is that I have a deep and underlying concern that the growth of individual desire to control everything in society and everything in one's life is a risk to the broader society. Sometimes an individual's desire to end their own life through assisted suicide does not take into account the people surrounding them. I think people are also prone to being influenced in an untoward way, and I am particularly concerned about elder abuse.

I have spoken to many people and thought about this topic long and hard, particularly since I was elected in March 2010, because I knew this topic was likely to emerge in this parliamentary sitting period. The issue of elder abuse, particularly, was raised with me by a cancer specialist, and I have spoken to several specialists. I have visited palliative care sites and heard about the difference that palliative care makes to people at the end of their life.

The one underlying concern I had when I spoke to this person—who had no particular religious perspective and did not work at a palliative care hospital that was of a religious nature—was his view that there are relatives and friends involved in people's lives at these very difficult, end of life transition

points, who say 'I am going on a holiday.' I know this sounds simplistic, but this person actually thought it was true, and I sincerely believe—when I see some of the constituents in my electorate who are vulnerable in their caring positions—that people may wish to say, 'Well, this is the day that this is going to happen.'

I do not think our society should be comfortable with that. There are frail and elderly people. I would much prefer our society discuss the end of life matters with advanced directives, improved palliative care and a more humane and civil way of actually protecting people who are in vulnerable situations. That is the way I will be voting on these matters before the house. For the record, I lay on the table that I am a Christian, but that has not come into my decision in this matter.

The Hon. J.J. SNELLING (Playford—Treasurer, Minister for Employment, Training and Further Education) (11:19): I think it will come as no surprise to the house that I oppose this piece of legislation. I want to address a few issues that have arisen over the course of the debate and the wider debate on the issue. The first thing I want to take issue with is this claim that euthanasia is something that is happening anyway: the doctors are doing it but in a completely unregulated way without oversight and, whatever the numbers are, many hundreds of people are euthanased by their doctors unlawfully all the time. That is an absolute nonsense.

The fact is that in the 1990s the previous Labor government introduced legislation which provided doctors protection should they administer palliative care and pain relief and as a foreseen but unintended side effect the person died. For many years—in fact, even before the legislation—it was always considered not to be murder: but, nonetheless, the law has been crystal clear in South Australian legislation that a doctor can quite lawfully administer pain relief to a patient in the knowledge that that pain relief might be administered to the extent that the patient may die and, if the patient does die, that is not considered homicide or murder under South Australian law.

That practice of providing pain relief, even up to the point where it might kill the patient, and in that knowledge, is all part of good clinical practice and good palliative care. It is not new and it has long been an understanding in the law, certainly since the 1990s. In fact, it came about as a result of a very far-reaching inquiry into death and dying that was chaired by my former employer, Martyn Evans, who went on to become a minister for health, and it is all part of good clinical practice.

The report that the select committee came up with was a far-reaching report into all the issues associated with death and dying. It resulted in an excellent piece of legislation, and members should go back and look at that report and piece of legislation, which addressed many of these issues very well and in a very well-thought-out, well-considered manner. The simple fact is that to claim that administering pain relief to the point where it kills someone is somehow akin to euthanasia is completely wrong and a complete misunderstanding of the true nature of palliative care.

My concern, of course, is that, like the Minister for Recreation and Sport, I am an opponent of euthanasia, full stop; and it would not matter how good the regulations were able to be formulated in a piece of legislation because I would always oppose the legalisation of the killing of South Australians. However, my greatest concern about this piece of legislation is that it removes any safeguard whatsoever. I acknowledge that, at least in previous legislation that has been introduced both by the member for Ashford and the member for Fisher, and other legislation that has been introduced in this house previously, there has been an attempt to provide a regulatory framework in which euthanasia might occur.

The Minister for Health (and I think the member for Ashford had a part in it as well) quite correctly identified how difficult and, I think he would argue, impossible it is to come up with a regulatory framework to provide for euthanasia with all the necessary safeguards, and I completely agree with the Minister for Health on that point. It is incredibly difficult, and that is one of the big reasons why many members of parliament over the years, while in principle supporting the personal autonomy arguments with regard to euthanasia, nonetheless have voted against it, making the argument that it is impossible to provide an adequate regulatory framework for euthanasia that provides all the requisite protections for the most vulnerable in our community. The Minister for Health, I think, correctly identified how difficult that was and the problems with the regulatory framework that was being put forward in the member for Ashford's previous piece of legislation, as well as, I think, the member for Fisher's previous piece of legislation.

However, in identifying the difficulties in that, instead of saying, 'Well, I don't think it's a good idea that we have euthanasia because it's too difficult to regulate,' what he suggested and put forward was,

'Well, look, this is too difficult an issue. Let's have euthanasia but without the regulation. In fact, let's leave it to the court to decide what might be the appropriate conditions upon which euthanasia might be lawful.' This piece of legislation essentially provides a defence to doctors who perform euthanasia, so that should a doctor be charged with a homicide, having given a lethal injection to a patient who was in the final stages of a terminal illness, that doctor would be provided in a court with some form of defence.

The problem with that essentially is that, if we were to pass this piece of legislation, we would be ignoring our responsibilities and leaving it up entirely to a court to make a determination about the circumstances in which euthanasia might be lawful and the circumstances in which it might not, and I think that is entirely unsatisfactory.

As the member for Newland, I think, correctly pointed out, if we must have a euthanasia bill, if we must debate a euthanasia bill, if we must pass a euthanasia bill, at least let the parliament decide what the conditions might be in which euthanasia might be lawfully administered. Let us not just leave it to a court and the personal predilections of an individual judge to make decisions which are going to be incredibly profound for South Australia as a whole.

We should not just be leaving it to the personal predilections of an individual judge to make such a determination and to make important decisions about the circumstances in which euthanasia might be lawful and the circumstances in which it should not. That is the reason for which we are elected, and we should be making determinations about those sorts of conditions that might apply.

But, having said that, of course I will always oppose any piece of legislation which attempts to make lawful the killing of South Australians. Essentially, this piece of legislation, I believe, is dangerously open-ended, and we really do not have enough before us in order to make an informed decision about which way we might vote on this piece of legislation. This piece of legislation, I believe, is dangerously open-ended.

Having spent some time on the specifics of this legislation, I will just address the issue of euthanasia overall and why, in principle, I think that euthanasia should continue to remain unlawful in this state. The proponents of euthanasia argue essentially from a principle of personal autonomy; essentially, 'It is my body, I should be able to decide what I want to do with it. If in certain circumstances I am threatened with a painful death, well, then, I should have the right to request a doctor to administer me with a lethal dose.'

I should point out that what we are talking about with euthanasia is not suicide. Suicide for many years has not been unlawful in this state. What is unlawful is for a person to assist someone in a suicide in some way; and, of course, what is unlawful is for someone to commit a homicide by administering some sort of lethal injection. We should make sure that we distinguish between suicide and euthanasia. Suicide, of course, can be prevented, but people who attempt to commit suicide, thankfully, are no longer prosecuted. The reason why I—

Time expired.

Debate adjourned on motion of Ms Thompson.

May 19 2011

Adjourned debate on second reading.

(Continued from 5 May 2011.)

Mr BIGNELL (Mawson) (11:24): I rise today to speak on this very important matter before the house, and I would like to begin by thanking all those people who have contacted me at my electorate office with their views on either side of the debate. I think it is very important that we respect both sides of the debate. It is a very passionate subject and one that people have very strong feelings either way on. I really feel very much for those people who have contacted me with some quite often heartrending stories of their own personal experiences.

It is one of those issues that has been at the forefront of most of our minds for the past few years with various bills before this place. Last year, we were looking at a bill that did not make it into this chamber but did make it into the upper house. I remember ebbing and flowing on what my vote would be on that matter. It seemed that the more people you spoke to the harder the decision became. I attended a briefing last year, organised by Tom Kenyon and some Family First members, and it was

very good to hear from some palliative care specialists and of their experiences and put palliative care into context.

It brought home an experience I had 10 years ago with my own father when he found out that he had three months to live. His first reaction was that he did not want to go through the pain of the three-month dying process. I guess something that we all have within our hearts is that we fear death and the pain associated with it, so dad's immediate reaction was to get on the phone and ring the voluntary euthanasia helpline. They were quite good. They did not counsel him any particular way; in fact, he found them very encouraging in that they did tell him to explore palliative care options but said, 'You might also want to read a book called *The Final Exit*.'

I went out and bought the book for him. It is subtitled, *The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. Dad wanted me to buy it, so I went to the store and bought it for him. In the intervening week, he had actually reconsidered his views on it. It is still in its wrapping and sits on my bookshelf in my parliament office as a reminder of my own dad's thoughts on the matter because it is something that is pretty hard to understand until you have lived through it or had a close relative live through it.

When we spoke to the palliative care specialists last year in parliament, they mentioned to us that when you do have that three months there is the chance of a miracle recovery, but there is also the chance for some bonding. That experience of dying, when shared with relatives, can actually add a dimension to a relationship. I know my personal experience was that at that stage I was working at the ABC as a sports journalist. I worked every weekend and had Tuesdays and Wednesdays off. My dad was a stock agent who had sales on Wednesdays, so his Tuesdays and Wednesdays were flat out.

He was 61, and you think that your dad is going to be around forever. What that three months did was give us the opportunity to spend practically every day together. My son, who was three at the time, and his other grandkids, also got to spend a lot of time with him. So, we need to bear in mind that that period can be quite an important time for those who are dying and the loved ones around them. I do not think I would have supported the bill that did not quite come to our house last year, but I do have great respect for the people who deliver palliative care in this state.

I think we are one of the leading states in the delivery of palliative care and I would hate for any action to be taken against a doctor or nurse who may in some way assist someone in the relief of pain and the process of dying. I can only talk about the experience I had, but dad's doctor was fantastic, and I would hate for anything to have ever happened to him, in the legal sense, because I know—well, I do not know exactly what he did—that he knew my dad's view and the family's view that dad was to suffer as little as possible. I cannot say for certain whether dad's death was brought forward, but we knew that that doctor was making the best decisions and providing the best care for my dad.

A couple of days before he died—we grew up in the South-East—dad wanted to go back to Penola, to Mary MacKillop's church to say his final prayers. This doctor sort of said, 'Look, Trev, you're not fit enough to do it, but we'll try a blood transfusion.' So, we all gathered on the Saturday morning of the June long weekend, 10 years ago—my sisters were in town from interstate—and the doctor did the blood transfusion. Then he came back in and said, 'Look, Trev, I'm afraid the blood transfusion hasn't really worked. You're not going to be strong enough to go.'

The SPEAKER: Just a moment, member for Mawson. Member for Ashford.

Second reading debate reading resumed.

Mr BIGNELL (Mawson) (11:40): I find it quite sad when we are talking about life and death issues that the members for MacKillop and Bragg want to talk about the rats and mice of the political process.

Ms CHAPMAN: I have a point of order, Madam Speaker. First, the speaker in making that statement is offensive to the matters that we are dealing with in relation to the charter of health and community complaints. It is not a rats and mice issue and I find it personally insulting, and I am sure the people who want this issue raised in the parliament feel the same.

The SPEAKER: There is not really a point of order because it is not something that we would consider a point of order; but, member for Mawson, I think you should continue with your remarks and refrain from making such comments.

Mr BIGNELL: Thank you, Madam Speaker, and I will return to the area I was talking about before the disruption, which is the health professionals who help people in their dying days. In particular, I thank all the staff—the doctors, nurses and all the other staff—at the Daw House Hospice where dad spent some time.

In those final few days when he was very weak, as I was saying before, he wanted to return to Penola near where we grew up in the South-East of South Australia to say his final prayers at the church where Mary MacKillop did so much of her work. He asked the doctor about this and the doctor—who had a great sense of humour and was very helpful and tried to help dad as much as he could—said, 'Look, Trev, you are too weak but if we give you a blood transfusion it might give you the strength to make that final journey to Penola.' It was the June long weekend.

The doctor came in after the transfusion and said, 'I'm sorry, Trev, the transfusion has not done its job and you are too weak to go.' The doctor left the room and I was thinking, 'Thank goodness for that,' because I did not really want to get in the Tarago with my sisters and make the drive down. Dad, in his normal, fairly stubborn way, said, 'Right, pack the Tarago: we are off.' My sisters duly met his wishes. I said, 'Dad, I'm not coming to Penola with you. It is going to be like *Weekend at Bernie's*, driving around the South-East with a dead guy in the car.'

That is the sort of thing I am talking about. In those final months you have your tears and your laughs, and we had lots of laughs. There was a lot of black humour between my dad and me, because I spent time driving him to medical appointments and to sort out his legal and business requirements in those final days. It is very hard to tell people not to fear death but, when you have lived through it with a close relative, you realise it is something that we all have to face up to and everyone is going to handle it differently.

Once again, I thank all those medical professionals with whom we came into contact in those three months before dad's death back in 2001. I stand here today not backing voluntary euthanasia but backing those doctors and nurses who do so much for people in their final days. So I will be supporting the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill.

Ms THOMPSON (Reynell) (11:44): As have other members, I have received a number of letters and various messages from people within my electorate and people outside my electorate.

As with other matters of conscience, my view is always to seek to allow all individuals to exercise their own conscience and provide a framework whereby, no matter what a person's religious or ethical views, they are able to enact them. I believe that today we have a society which is sufficiently mature to enable us to provide respect to the various views that are genuinely and very firmly held by many people within our community.

For those whose views mean that life must take all natural courses and not have medical intervention in many ways at all, such as some religious groups, I respect their views. For those who will accept a level of medical intervention but not to the extent that it in any way shortens life, I respect their views. For those who believe that they should have more control over the quality and quantity of life, I respect their views. This bill seeks to enable the participants in the process, and any doctors and any health workers, to enable that last group I mentioned to have their wishes accommodated. The wishes of the first two groups are already accommodated, but the wishes of the third group are not always under current laws.

Of the many communications I received, the one that best reflected and said far more eloquently than I possibly can the views that I hold came from Graham Nerlich MA, B. Phil (Oxon) FAHA, Emeritus Professor of Philosophy in the University of Adelaide. It was interesting that, on top of all the very heartfelt communications I received from doctors describing some very difficult situations in which they have seen their patients, it was a philosopher whom I found most useful in considering the rationale that I hold in relation to respect for people's views. Professor Nerlich writes:

> Doctors often face a cruel dilemma where a patient suffers an illness, injury or medical condition that irreversibly impairs that person's quality of life so that the life becomes intolerable to that person and beyond the reach of even the best palliative care. If the patient pleads for the doctor to end their suffering by ending their life the dilemma is especially agonising.
>
> The proposed amendment provides neither a direction, nor an advice nor a permission as to what the doctor may do in such circumstances. It imposes no duty on the doctor. It is merely a defence against prosecution brought against him or her, and any ancillary workers, in the event of their granting the patient's request.

> Ethically, each person has a right to their own life. The right imposes duties on others towards them. But it does not follow that people have duties to themselves to preserve their own lives under all circumstances. The state does not, and should not, prevent them from choosing to risk death in the ordinary course of life. It does not bar them from choosing deliberately, to seriously endanger their life, either in attempts to aid or rescue others. It does not even legislate against reckless risks, taken for frivolous thrills. Nothing prevents anyone from laying their life down deliberately in time of war, for instance. In the painful medical dilemma, patients may competently and responsibly choose to forgo their right to life. It follows that they thereby cancel the ethical duty on the doctor to oppose a patient's free and competent request in the circumstances described in the amendment.

He then adds that the AMA's clauses 10.3 and 10.4:

> …make it obvious what would move a doctor to take the step and risk prosecution: it is proper responsible medical compassion. Thus the proposed defence against prosecution is ethically justified. I support it in the strongest terms.

I think that says far more eloquently how I see the importance of this parliament enabling people to exercise their own conscience, make their own decisions and not stop willing practitioners from assisting people to exercise their own conscience. As said by Professor Nerlich, it does not impose an obligation on the doctor; it does not impose any particular rights on individuals. We already have a very good act relating to palliative care, but this enables people to make a decision to say, 'I have had enough.' It does not allow prior directives. It is very, very modest in what it does allow, but it does allow the parliament to give our citizens more rights in the exercise of their own conscience and their own views.

The Hon. A. KOUTSANTONIS (West Torrens—Minister for Mineral Resources Development, Minister for Industry and Trade, Minister for Small Business, Minister for Correctional Services) (11:50): I rise to exercise my conscience on this matter and to oppose the bill. I do so not in any way to attempt to criticise those who are proposing this. I do not think anyone who proposes this is not of goodwill, and I think that the same should be said of those who oppose legislation like this. I have been in parliament since October 1997, and I have opposed every attempt, every measure, to bring about this type of reform. I do so with one fundamental belief, that is, that doctors should do no harm. As the member for Reynell just said, this is a very modest step forward, but it is how you get larger change later—with modest reforms.

Personally, I feel that my conscience says that I must do all I can to make sure that no-one is harmed who does not wish it upon themselves. It is a very sensitive and difficult area in which to legislate. I completely sympathise with all the heartfelt cases used as examples for this legislation to be amended. However, examples do not make good law. It is a difficult decision. I make a point of letting my constituency know before every election my views on this matter. I do not attempt to hide it.

I know it is overwhelmingly popular in my electorate. In fact, I would go as far as to say that 85 per cent of my constituents support this measure, and I publically proclaim to all of them that I will be voting against it, and I said so before the election. I will say so during my four-year term, and I will say so again at the next election. The reason I say it is that I have a conviction that all life is sacred and that doctors should do no harm. With those few words, I oppose the legislation.

Debate adjourned on motion of Mrs Geraghty.

June 23 2011

Adjourned debate on second reading.

(Continued from 19 May 2011.)

Ms BEDFORD (Florey) (11:08): In response to insupportable suffering, when further treatment is clearly futile and death is near, it is a fact that many compassionate doctors currently do administer lethal doses of drugs in our hospitals and hospices. To quote former AMA president, Dr Brendan Nelson, 'Doctors who deny helping patients to die are either inexperienced or dishonest.'

The law today requires doctors to shroud their actions and intentions in secrecy. There are no second opinions, nor is psychiatric examination required. There is no requirement for witnesses or open and frank discussion between patient and doctor about ending life, as it is not now within the law; therefore, many of these deaths are without specific patient consent.

The shocking rate at which elderly Australians take their own lives, violently and alone, is testament to the need for law reform. The proposal before the house will bring honesty and openness to the end of life doctor-patient relationship. It does not legalise the actions of the treating doctor or assistant if they deliberately take someone's life. It simply provides a defence for the treating doctor who, through the same compassionate act now and at the request of a patient and in controlled circumstances, assists to end that person's life or assists them to do so themselves.

I have received numerous submissions from people from all walks of life who mistakenly view this bill as the legalising of voluntary euthanasia and therefore oppose it on religious grounds. However, there have been many others who do understand what the amendment is planning to do and have expressed their unqualified support. Among them is one of my constituents, a Modbury North resident, Mr Lionel Fiegehen.

Mr Fiegehen wrote to me about the circumstances around his late wife's recent passing and the difficulties facing her own medical practitioners who, despite her intolerable pain and suffering, were unwilling and unable, at her request, to put an end to that situation for fear of legal ramifications. He stated that his wife, a Catholic, felt the need to abandon her religious beliefs and even refused to see a priest at the end. He is deeply saddened that she should have passed away in this distressed state due to an outdated legal position.

It is important to note that the defence will only be available if the doctor is the patient's treating doctor. The patient must be an adult of sound mind and suffering from an illness, injury or medical condition which is terminal and has made life intolerable. The patient must make a lucid request to the doctor to end their suffering and, hence, their life. Few may wish to exercise this right; however, I would rather this right exist so that a patient can discuss their feelings and participate in this treatment option decision. That is why I am giving the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill my support.

Debate adjourned on motion of Mrs Geraghty.

July 28 2011

Adjourned debate on second reading.

(Continued from 23 June 2011.)

Mr PICCOLO (Light) (11:10): I would like to make a small contribution to this debate. There are a couple of general comments I would like to make first and then follow up with some specific comments regarding the bill itself. One of the things which has interested me in this debate (not only this issue but other issues) is some discussion about who has the right to actually make a contribution to the debate; who has the right to express an opinion about the matter. There is interesting commentary in the media about the role of churches and other faith groups and whether they have a legitimate right to make a contribution to this debate, and that they should not get involved in politics—that is the allegation.

I have a considerable difficulty in a liberal democracy when we start saying that certain people can make a contribution to a debate but others have to be excluded because the view being expressed may not be the popular view or the common view or a view which is helpful to the debate. This has happened not only with this issue but with other issues. The first thing I would like to say is that my view is that everybody has a right to contribute to the debate. Those people who are saying that churches should keep out of it I think are wrong. I may not agree with all that is being said by various parties but they certainly have a right to make a contribution to this important discussion, and any other discussion.

Interestingly, though, I find that the people who say that the churches should not have a say are often the people who are the loudest about protecting their right to have a say on other matters; yet they want to prevent other people from making a contribution to the discussion. By 'churches' I mean any churches, whether it is the church I belong to (the Catholic Church) or any other faith group. My view is that if they have a position or a view about a matter they have a right not only to express it but, in fact, I think they have an obligation to express it to provide input into any discussion.

The second issue of a general nature is that there has been some discussion in the public realm as to whether it should be a conscience vote or a party vote. The curious thing I found was that in some things I have read it was said that it should not be a conscience vote because people should just follow public opinion and MPs should be doing what the community tells them to do. It is interesting that, on the one hand, we have a body of people who say, 'Every issue should be a conscience vote and, as a result, we actually get a better democracy.'

The inconsistency here is that when a particular group think a conscience vote will help their particular view they will ask for a conscience vote; when they think a particular group may have a view which does not help, they will not ask for a conscience vote. I must confess, I am not clear which votes should be conscience votes and which should not. I have often debated that within my own party because so often I am not clear as to which issues have a greater element of conscience than others—but that is a discussion for another day.

However, I think it is important that the parties have declared it a conscience vote and we now have an opportunity to express our personal views on this matter. A very strong sentiment in the debate on this bill has been that the overall majority of people have expressed through opinion polls and surveys that we should support voluntary euthanasia. While it is true in a democracy that public opinion should be taken into account, and should have an input into decisions we make, if we were honest with ourselves, if you were to use popular opinion on every issue, there would be a lot of issues we do not agree with, for example, the death penalty.

There is still a lot of public opinion about the death penalty but we do not support that, so I think using popular opinion as the only basis for decision-making is flawed, and we as MPs, or any decision-makers, have an obligation to take into account all factors and make what is right for society as a whole, not only at this point in time but also what is right for society in the longer term. Public or popular opinion in many countries has led to some disastrous decisions where all nations have suffered.

Getting back to this debate itself, there are a couple of things I would like to mention. First of all, to some extent it has been portrayed by those who oppose this proposal, that it is essentially a euthanasia bill or a doctor-assisted suicide bill. As I read and understand it, the bill is not that at all. My understanding of this bill is that it does not in any way expand the overall concept which is put out

by the voluntary euthanasia people of the so-called 'right to die' or 'to die with dignity'. This bill does not do that at all.

I have expressed privately, and I am happy to express publicly now, that I would have not supported the alternative bill which was here before, which sought to expand the right to die. I would have had difficulties with the bill for a couple of reasons: firstly, I think that setting up some sort of public mechanism to resolve what is a very private matter would be the wrong way to go. We see this in America where people go to court to prevent those sort of actions, and what is a very private matter between a patient, their families and a doctor should not become a public spectacle.

My concern was that the bills which have come before us—which try for very good reasons, and are well intended—would potentially set up a system which would bring into the public domain people's situations which should be private between themselves, within their family, and also with their doctor. This proposal does not expand in any way the concept of the right to die and does not in any way sanction or give a right for doctor-assisted suicide and certainly not voluntary euthanasia.

I am relying here on some work done by Professor Colleen Cartwright, Professor for Ageing at Southern Cross University, who has spoken very eloquently on this matter of what we do in terms of public policy when people are near to the end of their life, particularly people with illnesses which are not curable and, secondly, the role of doctors in ensuring that they have a dignified life while they are alive and how we manage the issue around pain.

One of the leading principles that Professor Cartwright talks about is the principle of double effect. The principle of double effect goes back to St Thomas Aquinas, a well-known Catholic and theologian who had to tackle moral decisions or correct decisions at the time. Essentially, the principle states that, if you have a primary purpose for an action but may have a secondary effect not intended as an effect, there may be a moral basis or a strong case for taking that action. For example, if a doctor's primary reason to provide a patient with medication is to alleviate pain, and if an unintended, unplanned effect is that a person may end their life, the principle put by St Thomas Aquinas suggests that that action would still be moral and correct. That is important, because doctors have an obligation to ease the pain of people who are obviously ill and towards the end of their life. In fact, they have a moral obligation to make sure that people do not suffer.

The question arises: how do we on the one hand protect doctors who are acting ethically and morally in their everyday work? Secondly, how do we not extend the principle of the right to die, which I have mentioned I have a problem with. I think this bill as it stands does seek to achieve that balance and, as a result, I am likely to support it. I am not sure what amendments are intended at this point in time, but I would certainly be open to supporting this bill, because I think it does two things: first, it does not expand the concept of right to die; and, secondly, it does provide some framework for those doctors who need to care for patients who are dying.

The Hon. S.W. KEY (Ashford) (11:21): I thank members for their contributions in this house. We have had different and I think important contributions from the members for Morialta, Waite, Newland, West Torrens, Taylor, Reynell, Mawson, Florey, Fisher, Morphett and, most recently, the member for Light. I would like to thank my colleagues for their contributions.

The member for Light mentioned that it is my intention, should this bill get past the second reading, as it did last time, to move some amendments. I need to tell the house that those amendments are based on negotiations and discussions that I have had with the Australian Medical Association. We have not agreed on every single issue, and I am very happy to elaborate on that if we get to the committee stage. However, it is important to say that I have done my best, with the assistance of parliamentary counsel, to reflect most of the amendments that the AMA thought were important, particularly in relation to their members and this very important issue of medical defence.

I will emphasis for the last time in this debate that this bill seeks to provide a medical defence for a medical practitioner should he or she be charged with manslaughter, murder or assisting in suicide after receiving a request from a patient who is at the end of their life. I urge members in this house to support the second reading.

Bill read a second time.

In committee.

Clause 1 passed.

Progress reported; committee to sit again.

September 29 2011

In committee.

(Continued from 28 July 2011.)

Clause 2 passed.

Clause 3.

Mr GARDNER: I move:

Page 2, after line 23 [clause 3, inserted section 13B(1)]—After paragraph (b) insert:

(ba) the defendant referred the person to an independent medical practitioner (being a medical practitioner registered under a law of this state as a specialist in respect of the kind of illness, injury or other medical condition from which the person was suffering) who confirmed in writing the defendant's diagnosis that the person was suffering from a qualifying illness; and

(bb) the defendant referred the person to an independent medical practitioner (being a medical practitioner registered under a law of this state as a specialist in respect of mental health) who advised the defendant in writing that, in his or her opinion—

(a) the person was not suffering from depression; or

(b) if the person was suffering from depression, that fact alone did not cause the person to request the conduct to which the charge relates; and

Very briefly, during my second reading contribution on this bill I made it very clear that I could not support this bill without some significant changes, and, on that basis, I asked parliamentary counsel to prepare some amendments dealing with the issues that I identified. I might just go through them briefly once now, if that is all right, and then I can just refer members to this contribution and my second reading speech in future amendments.

The three significant aspects that I thought were most unfortunately lacking from the original presentation of this bill were, first, a clear determination that a request had been made by the patient. The amendments seek to require that that be in writing in the presence of an adult witness who is not the defendant or an employee of the defendant.

The second significant amendment that I propose, as I outlined in my second reading contribution—which I felt was a significant absence in the original bill—relates to the fact that I feel that it is important that a second opinion be provided. The amendment requires that the defendant (that is, the doctor) referred the person to an independent medical practitioner being a medical practitioner registered under a law of this state as a specialist in respect of the kind of illness, injury or other medical condition from which the person was suffering who confirmed in writing the defendant's diagnosis that the person was suffering from a qualifying illness.

For anybody who was seeking to go down this path, it would be an absolute travesty if they were wrongly diagnosed in the first place, and that is the reason for this safeguard being sought. The third major lack in the original bill, which I described as a litmus test issue, was a requirement for a psychological assessment. Therefore, the amendment I have proposed provides:

(bb) the defendant referred the person to an independent medical practitioner (being a medical practitioner registered under a law of this State as a specialist in respect of mental health) who advised the defendant in writing that, in his or her opinion—

(a) the person was not suffering from depression; or

(b) if the person was suffering from depression, that fact alone did not cause the person to request the conduct to which the charge relates;

For members, or anyone else who may be interested, I refer them to my second reading speech for more background—that is the basis on which I move the amendments today.

The Hon. S.W. KEY: I thank the member for Morialta. He has been quite consistent in his view about the need for these particular safeguards. I say 'consistent' because, in the negotiations I have had since the start of the year on this bill, there seems to have been different views about whether or not there was a need for a second opinion. I must say that people in the medical profession initially were opposed to the concept I had raised in discussion about whether or not there needs to be a second

opinion and whether there needs to be more than presumably the case notes that I understand a doctor, and certainly the health staff who are supporting the patient, would normally keep.

On that basis, when I had the bill drafted, I did not include those safeguards because the view just before the bill was drafted was that, in fact, they were not necessary. However, on reflection, and certainly from the feedback I have had from the community, it seems to me that the member for Morialta's amendments are warranted, and I certainly support them.

Members may notice that, on the basis of the feedback I have had most recently, including from the AMA, I might add, I have also tabled some proposed amendments that are very similar to the member for Morialta's amendments. However, I defer to him, and I would be more than happy to support the amendments the member for Morialta has put forward. I think they are well thought out, and I think they will work in the situation we are dealing with. On that basis, I will be withdrawing the amendments I have put forward, which are listed as 88(2) under my name.

The Hon. R.B. SUCH: I welcome these amendments. Without taking anything away from the member for Ashford, who I know is committed to people's wellbeing and quality of life, some people have called the original bill as presented to parliament a voluntary euthanasia bill. I do not believe it ever was or would have been in that format. It focuses on the medical defence aspect. I am not against that; I am just saying that I think it is wrong to call that original bill a voluntary euthanasia bill.

I think people need to remember that, when we are talking about voluntary euthanasia, we are talking about voluntary euthanasia, not euthanasia without the voluntary component. It is important that people's wishes and desires are respected and that we do not simply have a mechanical process which allows a medical officer to end someone's life simply on the basis of their own judgement.

The reality is, of course, that every day in South Australia medical people are making decisions about ending someone's life, either through increasing pain relief, or maybe even involving things like chemotherapy, to a point where it will ultimately bring about the end of that person's life. I think people who suggest that it is not happening are kidding themselves, but you are not going to get doctors coming out and saying, 'I helped end someone's life today,' because they do not want be put in court and run the risk of prosecution. It is a reality—even recently someone said to me that their relative was dying and that they hoped that the process could be speeded up so they put pressure on the medical officers to end the life sooner rather than later.

I commend the member for Morialta for his amendments. I think they are reasonable and sensible, and I notice that the member for Ashford is willing to accept them. I think they put some useful safeguards into this bill and ensure that it moves from simply being a bill defending the actions of a medical officer to ensuring that it is focused on the wishes of the person whose life is coming to an end. I welcome these amendments.

Amendment carried.

Mr GARDNER: I move:

Page 2, line 26 [clause 3, inserted section 13B(1)(c)]—After 'person' insert:

, such request having been made in writing and in the presence of an adult witness (not being the defendant or an employee of the defendant)

As I said before, all the amendments were outlined in my earlier contribution. Amendment No. 2 is the one specifically requiring that requests be made in writing and in the presence of an adult witness who is not the defendant or an employee of the defendant.

Amendment carried.

Mr GARDNER: I move:

Page 3, after line 14 [clause 3, inserted section 13B(2)]—After paragraph (b) insert:

(ba) the defendant referred the person to an independent medical practitioner (being a medical practitioner registered under a law of this state as a specialist in respect of the kind of illness, injury or other medical condition from which the person was suffering) who confirmed in writing the defendant's diagnosis that the person was suffering from a qualifying illness; and

(bb) the defendant referred the person to an independent medical practitioner (being a medical practitioner registered under a law of this State as a specialist in respect of mental health) who advised the defendant in writing that, in his or her opinion—

(a) the person was not suffering from depression; or

(b) if the person was suffering from depression, that fact alone did not cause the person to request the conduct to which the charge relates; and

Amendment No. 3 is very similar to amendment No. 1; in the drafting of a bill sometimes things need to be written twice obviously.

Amendment carried.

Mr GARDNER: I move:

Page 3, line 16 [clause 3, inserted section 13B(2)(c)]—Delete:

'request (whether express or implied) of the person' and substitute:

express request of the person, such request having been made in writing and in the presence of an adult witness (not being the defendant or an employee of the defendant)

Amendment No. 4 is very similar to amendment No. 2—similar text but in a different part of the bill.

Amendment carried.

Mr WILLIAMS: I have a couple of questions on the clause I want to ask the proponent of the bill. The bill seeks to insert into the Criminal Law Consolidation Act new section 13B, supposedly to correct or right a wrong, or to correct something that is missing.

This part of the act, where we are inserting this new section, is about offences against the person, namely murder, conspiring or soliciting to commit murder, causing death by an intentional act of violence, manslaughter, criminal liability in relation to suicide, criminal neglect, defence of life and property, defence of property, etc. My question is: how many people in the history of this state have been charged under part 3 of the Criminal Law Consolidation Act whose charge would fall within the ambit of this proposal or proposed new section 13B?

The Hon. S.W. KEY: I thank the deputy leader for his question. My understanding from both the AMA and the Law Society is that in fact this defence has not been warranted for quite some time. There has been some case law that has changed the situation, though, in that it is now possible under certain circumstances for a patient to refuse treatment and it is also possible for a patient to refuse to eat or have any sustenance, but I do not know what other members in the chamber think.

It seems to me that they are pretty extreme measures that a person would have to take to have their choice of ending their life under certain circumstances made possible. It seems to me that while people, as I understand it, have not been charged in the way that the deputy leader has described, things have moved on to the point where that defence—and certainly people in the medical profession have said to me that they believe that this defence should be made available to them.

Mr WILLIAMS: I thank the member for her answer. The other question I have comes up in both 13B(1)(a) and (b) and the same in 13B(2)(a) and (b) where we are talking about the defendant as follows:

(a) the defendant was, at the time of the conduct to which the charge relates, a treating practitioner of the person; and

The second part in (b) provides:

(b) the defendant believed on reasonable grounds that the person was an adult person of sound mind who was suffering from an illness, injury or other medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person...

My question relates to the words 'a treating practitioner'. Is it the intention that that treating practitioner is the person or the doctor, I presume, who has been treating that particular illness or is it somebody else who has come in for another purpose?

The Hon. S.W. KEY: I think that is a really important question. If you look on page 4 of the bill, a medical practitioner is described as:

a person registered under the *Health Practitioner Regulation National Law* to practise in the medical profession (other than as a student);

Then there is a definition of 'treating practitioner':

of a person, means a medical practitioner—

(a) who is currently treating the person for his or her qualifying illness; or

(b) who is currently responsible (whether solely or otherwise) for the primary care of the person.

With the contribution and the passing of the amendments by the member for Morialta, we now have other health professionals involved in the process. As the member for Morialta has actually moved, and we have agreed to, that would include a person who is an independent medical practitioner—so we have now introduced that person into the process—and also, where necessary, an independent medical practitioner being registered under the law of this state as a specialist in respect of mental health as well as, as you know, the amendments seeking documentation that would support the request from the patient.

Mr PICCOLO: I will ask a couple of questions, if I could, similar to the questions raised by the Deputy Leader of the Opposition. In new section 13B—and this is one of the issues that seems to be sending out a mixed message, even though it is not intended—are the words 'if the death resulted, or was intended to result'. A lot of people have read that as given approval or seeking to allow doctors to undertake euthanasia with a patient. Can I perhaps get an answer about what the purpose of the wording in that section is?

The Hon. S.W. KEY: I would like to thank the member for Light for his question. The reason that has been put into the legislation, as I understand it, is to make sure that there is a comprehensive defence, and that would include conspiracy for murder. So we wanted to make sure that, through the legislation, we have put forward a defence that is as good as it can be. Obviously the defendant would still need to argue their case, they would still need to justify the process that they went through, but it was felt that that needed to be in there as well.

Mr PICCOLO: In clause 9 of its position statement dated 18 May 2011 the Australian Medical Association of SA states:

For reason of clarity the AMA(SA) considers it necessary for there to be a statement at the beginning of the Bill to the effect that the intention of the amendment is not to legalise euthanasia.

Could this clause be amended to clarify that?

The Hon. S.W. KEY: Members would have heard, when I was discussing the amendments that are being proposed by the member for Morialta, that as with any bill there has been a series of discussions about what should be in or out of the bill; what amendments need to be there. It has certainly been a moving feast with regard to the Australian Medical Association's position on what should be in and what should be out.

At the meeting I had with them last Thursday, despite all the work that had been done (not only by our parliamentary draftsperson but by different council members of the AMA), I decided that that was not necessary as an amendment. It is very clear that this is not a euthanasia bill; this is a defence for a medical practitioner who accedes to their patient's request under certain conditions for murder, manslaughter and assisting in suicide.

This is not a euthanasia bill and I think members in this house understand that, although they may have some concerns with the bill itself. But I think that has been established and I do not think it is necessary in this bill.

Mr PICCOLO: In clause 8 of the same position statement the AMA(SA), when they talk about clause 13B, state that clause 13B should be changed to omit the palliative care reference in 13B(5) and amended to the following. I will read the quote because I think it is very important because I will be seeking the members' response to their suggestion:

> Parliament intends that conduct bringing about the end of a prescribed person's life is a reasonable response to such suffering in exceptional circumstances—

and this is the bit they add—

> including where the prescribed person's suffering cannot be effectively relieved other than with treatment that has the effect of shortening life.

Does that clause, in effect, widen, if you like, the intention of the bill to actually legalise euthanasia?

The Hon. S.W. KEY: Not being a lawyer I am not really sure how to answer that specifically except to say, along with what I have said in the past, that the discussions with the AMA were quite lengthy and ongoing and on balance I did not see the need for that particular amendment. Talking about palliative

care I need to emphasise that like many members in this house I am a big supporter of palliative care. Like many of you, I have done fundraising in the area and I think that it is a really important part of our health system.

In saying that I am also aware of the number of people in the community who have argued—particularly the medical profession—that palliative care does not always work; it is not always the answer—depending on who you talk to. I refer to the recent opinion piece by Dr Roger Hunt in the *The Advertiser* where he says:

> ...despite optimal palliative care, and 5-10 per cent persistently ask clinicians to hasten their dying. Patients have a right to the relief of suffering, and doctors have a duty to relieve it.

So it is an area that certainly is of concern to many doctors, but I did not see why we needed to take out the reference to palliative care and decided not to.

Mr PICCOLO: I apologise if this question has already been asked prior to my entering the chamber. Can the member also just clarify why this proposed section 13B seeks to amend the Criminal Law Consolidation Act and not the palliative care act?

The Hon. S.W. KEY: The reason I would give, member for Light, is that this is not a voluntary euthanasia bill, although I have a bill on the *Notice Paper*, as members know, that amends the Consent to Medical Treatment and Palliative Care Act which is where I believe the voluntary euthanasia provision concerning the choice of voluntary euthanasia should be. This is a different attempt to look at defending the medical profession and the people who work with them if they are charged with a particular criminal offence.

The Hon. R.B. SUCH: Can the member for Ashford advise what legal or other advice she has had that suggested that the provision of her bill and these clauses would clarify and codify the criminal law to a point where it removes any ambiguity or vagueness or black hole, if you like, in the provisions of the law? Has she had any legal advice or advice from practising medical officers indicating that this bill and these particular clauses will clarify the law and codify it to a point where doctors will no longer be operating in an area that is subject to vagueness and possible misinterpretation?

The Hon. S.W. KEY: I thank the member for Fisher for the question. I have had considerable advice. I have relied very strongly, obviously, on our parliamentary draftspeople who, as far as I am concerned, are the experts in our lawmaking, but I have also sought advice from people whom I know operate in the criminal law area, as well as a number of doctors who practice in the end-of-life part of medicine and have raised with me the need.

As I said, things have changed particularly recently with the understanding that a patient can actually take action of their own accord and refuse to have sustenance, refuse to have treatment, and obviously die a very unpleasant death in many cases. Doctors—certainly the ones who I deal with and have talked to—are very concerned about that option for their patients and feel that they should be able, under certain conditions and obviously with proper safeguards, to accede to their patient's wish.

Mr PEGLER: I just have one question on the treating practitioner. If, for example, I was in hospital and somebody in my family has power-of-attorney, can they change my treating practitioner? Can that treating practitioner then proceed down this course of euthanasia?

The Hon. S.W. KEY: My understanding of the state of play with regard to advanced care directives is that depending on—are you talking about a medical power-of-attorney, for example?

Mr PEGLER: Yes.

The Hon. S.W. KEY: My understanding would be that, if you are giving your rights as a patient to someone else to act on your behalf, there would need to be some discussion with obviously the person who has your medical power-of-attorney but, at the moment, voluntary euthanasia is illegal, so I cannot see how someone who has medical power-of-attorney could make that decision.

This bill is very specific about the patient themselves, so I am not seeing anybody else being able to make that request. They have to be of sound mind and they have to qualify by having basically an irreversible condition, illness or injury, so that it does not look like they are going to get better any time soon and their situation is intolerable. It really is centred around the doctor-patient relationship, and it is centred around the patient in this particular defence.

Mr VAN HOLST PELLEKAAN: Member for Ashford, keeping away from the issues of whether euthanasia is appropriate or not appropriate, and sticking really to what the substance of your bill is about, as I understand it—that is, the medical defence aspect—are there any other examples you can give where there is a parallel in legislation?

By way of example, there is a legal defence for police officers against speeding if they are speeding in the course of their work, but it is not a legal defence against speeding purely for the purpose of speeding, so I do not consider that as a parallel. Are there any other parallels where this would be a legal defence that a doctor could use if necessary, if charged, to avoid criminal prosecution for ending a person's life, when the purpose of what they were doing was actually to end the person's life?

The Hon. S.W. KEY: While I understand that is a very good question, I do not know if I can give you a legal response; I am not a lawyer. The only defence that I think is probably closest to what I am talking about in this bill is the defence of provocation.

I think most people have heard of the 'battered woman syndrome', which I think is an unfortunate term. If someone in a domestic violence situation kills their partner or spouse and can argue that they have actually been provoked to do so, and there is a history of reasons why it has ended in the way it has, then there is a defence that is taken on board. I cannot give you any other legal precedents because I am not in a position to be able to do that as a non-lawyer.

Mr VAN HOLST PELLEKAAN: I respect that, and I am not a lawyer either, so I was not really looking for a legal answer but more of a community parallel. This is suggesting to offer a legal defence to a doctor who may or may not have committed what is technically a crime, when the intention of what they were doing was to commit the crime.

As I said, it is a different thing with speeding because the legal defence is that you would not be prosecuted for speeding because your purpose was not to speed; your purpose was to speed to achieve something else. I understand what you are saying about the 'battered wife syndrome'—and I agree, it is an unfortunate choice of words, but it is one that we would all understand. Is there any other way you could describe this bill, other than a legal defence, if charged for an action that was taken when the intent was specifically take that action and no other intent?

The Hon. S.W. KEY: I am not quite sure if I understand the question precisely, but basically what this bill seeks to do is provide a defence under certain circumstances. As I was saying earlier, the crucial thing for me is that there is a request made—and now, with the amendments that the member for Morialta has put up, it is a very clear request. There is a witness to the request, there is written documentation to the request, and there is also an independent doctor and, where necessary, a doctor with mental health expertise, as part of that process.

I think the trigger is that the request comes from the patient under certain conditions, and the next part is that there are checks and balances in place to make sure that the request is one that has come from the patient and that it is a serious request.

Mr PENGILLY: The question I put to the member for Ashford (and I have the utmost respect for the member for Ashford; I am not into platitudes, but she is a very good member and a very good lady), but the nagging doubt in my mind at all times with this type of legislation is that you have the absolute villain (or villains) like Dr Patel. There is no question that, overwhelmingly, the vast majority of doctors are wonderful people and do the right thing.

However, if you have a Dr Patel, a wolf in sheep's clothing, and another one of similar views—a psychiatrist, mental health expert or whatever—there is no provision to pull up these people and find them out. If this legislation were to go through they can use the defence mechanism via the legislation to get themselves out of trouble. I have this great nagging doubt in my mind that you cannot always be sure that everybody will act in the right way.

I am dreadfully concerned, member for Ashford, that there are evil conspiratorial people in this world and this nation, and that is the way it is. I cannot be sure that that may not happen; therefore I cannot support the bill, but I would like the honourable member's response to my concerns.

The Hon. S.W. KEY: I thank the member for Finniss for raising what is a very serious concern. My view would be that, whether or not this bill was around, there are people with evil intent. I am not sure that it really makes any difference one way or the other. The only thing I would say is that, because we have now shone a light on what is actually happening in many of our health areas, certainly people are aware that a proper case needs to be put.

Also, we have a whole lot of tests we have in this legislation that would need to be put forward for someone to be acquitted of a very serious crime, whether or not the patient actually dies. I share the view that there are evil people out there, member for Finniss, but I do not think this bill, if it passes, will either ensure that it does or does not happen. That is about the best answer I can give.

The Hon. R.B. SUCH: On my understanding, the actions of someone like Dr Patel would not qualify under this bill, and certainly not with the amendments moved by the member for Morialta. Neither would this legislation meet the criteria with the behaviour of Dr Shipman, who was even more notorious in the UK. As I indicated earlier in committee, doctors generally do not come out and say, 'Look, today I ended five lives.' Has the member for Ashford had any strong indication that doctors are doing this anyway, and doing it under the umbrella of a very grey area?

They are not sure that what they are doing is potentially a criminal act, and the fact that very few people have been brought before the court does not negate what I believe is the fact that, every day in South Australia, people are having their lives ended by doctors. I guess the issue is the intent: they do not intend to kill them, but they know full well that what they are doing will kill them, through pain relief or sometimes chemotherapy.

The Hon. S.W. KEY: I thank the member for Fisher for his question. Many doctors and people who come into the electorate office have talked to me about those situations that the honourable member has just mentioned. It is interesting that in one of the public articles put forward by a palliative care doctor that he says:

> Commonly the only way to relieve suffering is with treatments that can hasten death, like continuous terminal sedation, accepted by palliative medicine specialists and the AMA.

I think that answers the member for Fisher's question; it is well known and publicly acknowledged.

In my second reading speech, I talked about the AMA policy and code with regard to relieving suffering and pain. It is obvious that in some cases that medication also hastens death. When I answered a question from the member for Finniss, I mentioned that part of what this bill will do if it does become law is make it a lot clearer about what really goes on.

I have had personal experience, as have my constituents and people out there in the community. Hundreds of people have written to me about their own or their family's circumstances, where they really wanted their doctor to shorten their life because of serious health issues that they or their family member experienced.

My understanding is that it does happen at the moment. I mentioned earlier the changes that have occurred over time regarding the rights of patients. I think we should be prepared to make sure that 99.9 per cent of our medical doctors and health staff are actually supported and have a defence.

Mr BROCK: First, I understand the member for Ashford's passion for this matter, and I compliment her for bringing it up. However, from my observation, this bill was for medical defences of a specialist who may bring forward the end of a life through whatever it may be. Unfortunately, it has now become very confusing in the public arena. We have two other bills going before this house: one from the Hon. Bob Such and also one on palliative care. The media is calling this a euthanasia bill, and that is where it is getting confused in the public arena. I think that is one of the things that needs to be clarified: this bill is about a medical defence for the medical practitioner.

The member for Mount Gambier's question was: if I have medical power of attorney for my parents, or whoever it may be, and the specialist attending my family will not go forward and accelerate the end of life or suffering for that particular person, what stops me from then going to another doctor who may be a bit more receptive to going in that direction? Have we thought of that?

The Hon. S.W. KEY: I guess there are two things about this bill that I would point out in particular. There is the definition I read out earlier of the medical practitioner and the treating practitioner, about who they are. The treating practitioner of a person means the medical practitioner who is currently treating the person for his or her qualifying illness, and who is currently responsible, whether solely or otherwise, for the primary care of that person. With the amendments that the member for Morialta has successfully incorporated into this clause, we also now have an independent medical practitioner, and, where necessary, a medical practitioner who has expertise in mental health.

We have an independent witness and we also have documentation. I think they are all important things to take on board. Just getting back to the substance of your question and also the question that

the member for Mount Gambier asked me, regarding the person who makes the request, clause 13B(1) of the bill provides:

> (b) the defendant believed on reasonable grounds that the person was an adult person of sound mind who was suffering from an illness, injury or other medical condition that irreversibly impaired the person's quality of life so that life had become intolerable to that person (the qualifying illness);

It is specifically talking about the patient-doctor relationship and the request of the patient. So, I think that answers your question.

Mr BROCK: Thank you, member for Ashford. That is on the *Hansard* now, and I can explain it to my constituents. I have had nearly 2,000 or more people write to my office—

An honourable member: Is that all?

Mr BROCK: That is a lot for my area; and 65 per cent of them are urging me to vote against this bill. So there is a lot of confusion out there—

Ms Chapman: It is only 10 per cent of your electorate.

Mr BROCK: It is only 10 per cent of my electorate, that's right. However, it is very confusing for the general public to understand where we are trying to go with this bill. Now that I have a bit of clarity on it I will go back to my people.

The Hon. S.W. KEY: Just in response to that, the member for Frome has been quite thorough in making sure that people in the electorate of Frome are clear about information, and I compliment him on that. He has, like a lot of us, been trying to make sure that not only does he stick up for his own principles but that he also listens to what the electorate says. So, congratulations.

Can I also say that I think there has been some deliberate mischief that has happened with this debate. It serves the purpose of people who do not support voluntary euthanasia to argue that this is a voluntary euthanasia bill, but I guess the interesting feedback on all of that is that people in South Australia actually support voluntary euthanasia on the whole. Although there have been a few people in Ashford who have said to me that they do not support the amendment to the Consent to Medical Treatment and Palliative Care Act I have on the *Notice Paper*, very few people have said that they do not support the medical defence bill.

Once you explain that this is a medical defence bill—it does not mean that the person is going to get off, it does not mean that this will be a fail-safe way to start killing patients—then they feel quite comfortable with it. Obviously, if something gets into a law court you still have to argue your case. The only difference this will make is that parliament, if it accepts this bill and it becomes an act, will make it clear to the courts that we have considered, under certain conditions, the request of a patient to their doctor and that we are emphasising that doctor-patient relationship, with safeguards.

Mr WILLIAMS: I am somewhat confused at the member of the Ashford's claim that this is simply a medical defence bill and not a voluntary euthanasia bill. Let me explain. My understanding of voluntary euthanasia is that if someone wishes to end their life, by and large in this world, we would ask a medical practitioner to aid us in that wont. If that came to pass, we would have been through the process of voluntary euthanasia. That is my understanding; I might be completely wrong in that.

The member for Ashford's bill proposes that, as part of the medical defence, the defendant has to prove, on the balance of probabilities, that (and I am quoting from new 13B(1)(c)) 'the conduct to which the charge relates occurred at the express request of the person'. I am pretty sure I heard the honourable member say (because I wrote a note to myself) that it has to be proved that they are acceding to the patient's wish, and it certainly seems to comply with that.

I think the member for Light asked a question earlier about why the honourable member did not put a clause in this bill that expressly says this is not about voluntary euthanasia. I must admit that I am very confused. I think I understand what you are trying to do. I think you are trying to provide a defence for a doctor who is providing, I guess in most cases, palliative care—and probably extreme palliative care—but the doctor knows that it is going to bring about the death of the patient. Notwithstanding that, the doctor is doing exactly what he or she has been trained to do, and that is their role, but when you introduce subclause 13B(1)(c), which I read out—that is, 'the conduct to which the charge relates occurred at the express request of the person' involved—I think it brings a whole new element and, in fact, does make this a de facto voluntary euthanasia bill.

The Hon. S.W. KEY: I guess we are going to have to agree to disagree on whether this is a voluntary euthanasia bill or not. In my view, I am a supporter of voluntary euthanasia as a choice. I think it is best placed in the bill that I have before parliament, which is amending the Consent to Medical Treatment and Palliative Care Act. I think that is the place where the choice for those cases of people who cannot be dealt with, with regard to palliative care, needs to be.

I guess I have a more radical view about voluntary euthanasia as well, in that I think that there needs to be a lot of thought put into the patient's request. I am more interested in the patient's request and their view about what is intolerable than what the community view might be or what other people's views might be. Obviously, that needs to be qualified with proper medical advice and support, but that is the view that I have.

This bill, should it become law, will only provide a defence should someone—the treating doctor and the associated medical staff—be charged with murder, manslaughter or assisting suicide. You read the relevant section from the Criminal Law Consolidation Act, so I do not need to tell you about that. It is just to provide a defence under certain circumstances. That is what the bill is about; it is not a voluntary euthanasia bill. The AMA has its view, and I think the member for Light asked me that question. On balance, I did not see the need to put that in there.

The ACTING CHAIR (Ms Bedford): I am mindful of the fact that we can only really have three contributions from each member. This is your third.

Mr PICCOLO: Yes, this is my third.

An honourable member: He has lost count.

Mr PICCOLO: I haven't lost count. My question to the member for Ashford is as follows. I just want to clarify because some of the language being used this morning, whether by accident or intention, is starting to really blur this issue. I think I understand what this bill is intending. My question is: irrespective of who makes the request to actually end a life, if the doctor, for either the sole or primary intention, was to end a person's life, would this bill provide a defence?

The ACTING CHAIR: Do we understand that question?

The Hon. S.W. KEY: I am not sure if I do, Madam Chair. I need to report progress first of all, as I understand it.

Progress reported; committee to sit again.

October 20 2011

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for Mental Health and Substance Abuse, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (10:51): I move:

That standing and sessional orders be so far suspended as to enable the moving of a motion forthwith for the rescission of votes taken in committee of the whole house on the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill.

The SPEAKER: There being an absolute majority present, I accept the motion. Is that seconded?

Mr PEDERICK: Yes ma'am.

The SPEAKER: Minister, do you wish to speak to it?

The Hon. J.D. HILL: Madam Speaker, the reason I am moving this—I am sorry, I have never done this before and I do apologise to the house, particularly as this is during private members' time—the honourable member for Morialta moved some amendments to legislation which had been introduced by my colleague the member for Ashford.

These amendments were passed on the voices of this place, there was no vote called, and I was not aware that these amendments were being proposed. If I had been, I would have come in here and spoken against them, and I would like to have the opportunity to do that, and I could go to the substance of why I feel that way—but I assume that is what I need to do next. So, if the house would support this, then I would go into the substance of that particular set of measures.

Motion carried.

The Hon. J.D. HILL (Kaurna—Minister for Health, Minister for Mental Health and Substance Abuse, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts) (10:53): I move:

That all the votes taken to agree to amendments to clause 3 in committee of the whole house on the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill be rescinded.

The SPEAKER: Having counted the house, and there being an absolute majority present, I accept the motion. Is that seconded?

An honourable member: Yes, ma'am.

The SPEAKER: Minister.

The Hon. J.D. HILL: Thank you, Madam Speaker, and I thank the house for the indulgence, and, in saying this, I do not want to be critical at all of the intentions of the member for Morialta, but I think the consequences of his amendments are worth considering in greater detail. My original support for the proposition by the member for Ashford was based on establishing an arrangement whereby a doctor and a patient together could determine what was in the best interests of the patient in a particular set of circumstances and then allow that doctor to defend his or her decision in the face of the law, produce what evidence they thought was appropriate in that context in the law and let the law determine it. I still think that is the right way of doing it.

Obviously, a prudent doctor will do whatever is necessary to ensure that there is evidence to support their actions and I would expect, as has happened in other jurisdictions, that organisations like the AMA or the College of Palliative Care Physicians, or some other group of that type, would come up with some guidelines and best practice which would indicate a pathway that the doctor should go through if they were going to demonstrate that they acted in good faith.

What concerns me about the proposition that the member from Morialta has moved is the same concern I had with the legislation which has been moved by the member for Fisher and the member for Ashford; that is, it is the parliament that is putting itself in the position of what is the best way of developing that approach. What the parliament is saying is that, if you go through these approaches, then that satisfies the law. I do not think that is good enough. I think the law should be able to look more deeply than that.

I think the notion of being able to tick a couple of boxes creates too easy a pathway in one sense, then, in a practical sense, it creates too difficult a pathway. In a practical sense, the doctor and the patient may be in a situation where there is not time to get the two experts in, to go through the processes that are required. You may find experts are not willing to participate readily. It might be in

the middle of the night; they might not be available; it might be in a remote community; it might be in somebody's home. What is likely to happen, in my opinion, is that you will get experts who are willing to tick off on practically anything, who do not go through the proper rigorous process.

The intention might be undermined by the practicalities that would surround it. That is just my view and I know others will have other views about it. I sincerely support the proposition generally from the member for Ashford, but I want the law itself, the common law, to establish over time the appropriate process that a doctor would need to go through in order to be able to defend themselves, not have us here come up with a tick-a-box kind of solution.

That is my opposition to this proposal. I know it is sincerely meant and I know it is meant to give greater protection and the appearance of greater protection, but what I am saying to the member of Morialta is that I think it actually has the reverse effect. I do not say this as a matter of sophistry; I say this very sincerely. Having talked to doctors who work in this field, I think they would agree with me. So that is the heart and soul of my objection to this.

I would also point out while I am on my feet that the second set of amendments, which have yet to be considered by the house and which are similar to these, would have an even stranger consequence, because they would apply to a person assisting a defendant doctor, who may well be a defendant themselves. The effect of the second set of amendments would be that if a doctor and a nurse were looking after a patient, the doctor, in order to have a defence, would have to have sought these types of expert advice. If the second set of amendments were carried, that would mean the nurse would also have to have her or his own specialist advice. So you would end up with two lots of specialist advice for those two to be successful. I do not think that is what the member from Morialta intends, but my reading of it is that that would be the consequence.

I would say to the house, have the strength of your convictions on this matter by all means, but please consider the consequences of the amendments. I strongly support the proposition in its original form. I think that will go a long way to making the process of dying in our state that much better. I do not think these hurdles that have been put in place deliver the kind of benefits which I think the member for Morialta might hope for.

Mr GARDNER (Morialta) (10:59): I thank the Minister for Health for his comments. I was a bit confused because I understood that the main reason people were concerned about the amendments that were moved last week had been flagged in my second reading speech. I asked parliamentary counsel to file them some weeks before the debate occurred so there was certainly no intention of jumping the parliament.

I am aware, and the minister is aware, of the safeguards that they were intended to create. My understanding was that the concerns that have been raised with me by groups such as the AMA and a number of doctors for whom I have some significant respect, was that the amendments that would create safeguards in the case of euthanasia would create impositions on doctors practising palliative care under our current arrangements.

That would be the last thing that I, and I believe any other lawmaker here, would want to do because in the early to mid 90s this state was groundbreaking in the way that it dealt with palliative care. A predecessor in my seat, the Hon. Jennifer Cashmore, was instrumental in drafting those original laws that have created the opportunity for so many South Australians to pass with less suffering than they would have otherwise, and in the company of their families in some comfort.

If the argument is based around palliative care, and if there is some advice that suggests that the amendments would create impositions on the conduct of palliative care, then I could certainly be persuaded along those lines. If the arguments are as they were put by the Minister for Health, that the amendments removed from this parliament, the authority to determine the restrictions that would surround the application of euthanasia, then I would not support the rescission because I appreciate that the Minister for Health comes with the very best of good faith, as we all do in serious debates of this nature, but I have to disagree with him on a couple of the things that he said.

First, he was right when he said that the prudent doctor will keep good records, but I think when we are dealing with an issue such as this we have to be wary of the imprudent doctor, or the doctor acting without good faith. He made the point that an organisation like the AMA would come up with the guidelines and the common law would inform the process but, before we open a door such as this, if we are to do so, I do not think that that is good enough.

As I said in my second reading speech, the idea that a doctor may have this defence available to them without the imposition that the primary diagnosis must be tested by a second opinion, or with the requirement that the patient must be seen by mental health specialists who might determine that the person is not seeking euthanasia as a result of a depression which can be treated, is a terrifying concept to me, and always has been throughout the years that I have been discussing this through youth parliament, through public policy debate, through forums with doctors and others.

The SPEAKER: Member for Morialta, we are really straying into debate on the bill. The motion before the house is that the amendments to clause 3 be rescinded. We are really straying into the debate which we should come into when we get to the committee stage. So I would ask you to draw your remarks to a close.

Mr GARDNER: Thank you Madam Speaker for your guidance. I make the point that the subject of the amendments that we are seeking to rescind is exactly on the subject matter of the second opinion of a psychological analysis, the mental health specialist, and the third issue of the amendments that the motion before the house seeks to rescind is in relation to the witnessing of the request. The original bill, pre-amendment, required that the doctor had received consent but put no obligations upon the doctor in the manner of the evidence that might be presented.

Again, as I said in my second reading speech, that to me would not be an acceptable circumstance. I come back to the original point of view that for me to consider any sort of bill being presented, those are the three litmus tests for me, and then we can talk about the other things. I remain open to this motion if somebody can convince me that it will affect the palliative care outcomes in South Australia but, as yet, that argument has not been made.

Motion carried.

The SPEAKER: The bill now stands committed for consideration of the committee of the whole house.

The Hon. S.W. KEY: Madam Speaker, before you leave the chair, could I clarify with you where we are at the moment? There seems to be a few confused people. I understand that we are now going back into committee?

The SPEAKER: Yes.

The Hon. S.W. KEY: At that stage we will consider, obviously, the first amendments which were put up by the member for Morialta and which have now been rescinded. The debate in the committee stage on that has now gone, and we are now back to clause 1, presumably—

The SPEAKER: Clause 3; we are on clause 3.

The Hon. S.W. KEY: We are back to clause 3. I understand that some amendments have been filed that are not the Morialta amendments. I am just wondering whether we can clarify what the amendments are before us, because I am not totally clear; and, as the mover of the bill, I think that it is probably appropriate and probably polite that I am aware of what amendments we are about to deal with.

The SPEAKER: I understand that we have four schedules of amendments to be considered. It will be the normal procedure for a bill—all the amendments that have been submitted will be considered.

The Hon. S.W. KEY: I am only aware of one amendment that has been filed, so I am wondering whether we can clarify what those amendments are. Can we do that in committee?

The SPEAKER: I think that we need to do that in committee. I remind members—if people are feeling upset—what has happened. The previous motion was about rescinding. I allowed some indulgence for people to speak, but we really need to get into the committee stage for members to be able to say the things they want to say. We will now go into committee.

In committee.

Clause 3.

The Hon. S.W. KEY: Madam Chair, can I clarify the process?

The CHAIR: I am sorry; I am just clarifying something myself. I apologise to everyone for the moment of consideration, but this is obviously quite complex and we do not want to get it wrong. There are many, many amendments. Some amendments seem to be very new.

The Hon. S.W. KEY: I wish to just clarify the process. My understanding is that last time we were in this chamber, in this committee, I withdrew the amendments I had proposed, which is 88(2), and I stand by that. So I assume that we will not be dealing with 88(2). At the death knock (so to speak) minister Kenyon tabled 88(3), so they are now filed, and this morning we have received amendments from the member for Taylor, which is 88(4).

The CHAIR: I have just got that.

The Hon. S.W. KEY: So that I can be clear, are we now proceeding with 88(1) or is that in the realm of the member for Morialta to decide whether we go back to that, or does the decision we made in the house mean that those amendments are not now going forward?

The CHAIR: I understand that we will be treating this—as we should—like any other bill. We are not treating the amendments in the order they have been given to us here; we are treating them in consequential order. Does that make sense?

The Hon. S.W. KEY: Yes.

The CHAIR: Good. Member for Newland.

The Hon. T.R. KENYON: It is my intention to withdraw my amendments, not to proceed with them, if that helps the situation. All the amendments I have circulated, standing in my name, I will not proceed with.

The CHAIR: This is very good; now we have fewer bits of paper.

Mr PEDERICK: I want to make a general contribution with regard to clause 3, if that is appropriate. I think clause 3 is fairly general—

The CHAIR: Clause 3 seems to a giant megalith sort of clause. It would be good if, as you are going along, you could tell me what specific bits of clause 3 you are referring to—if possible.

Mr PEDERICK: I want to speak about the bill in general terms, and I think clause 3 gives me that leeway. I would like to bring members' attention to the Consent to Medical Treatment and Palliative Care Act 1995. I am sure many members in this house and in the other place have researched this act and what it does in terms of the arrangements for medical care or treatment for people, whether they want to give forward directives on what care they do or do not require should they not have the capacity to make that decision. Part 2—Consent to medical treatment, division 2—Anticipatory grant or refusal of consent to medical treatment goes through a whole raft of clauses about what can be done there.

To cut to the chase, in the palliative care act are the arrangements we are obviously talking about, in the bill before the house, about the protections for doctors and medical personnel in case they be charged with some form of criminal offence if a member of the family wants to bring that on. I just bring to the attention of the house Division 2—The care of people who are dying. Section 17 states:

> (1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress.

I think that is a very important part of the current act. Subsection (1) continues:

> (a) with the consent of the patient or the patient's representative; and
>
> (b) in good faith and without negligence; and
>
> (c) in accordance with proper professional standards of palliative care, even though an incidental effect of the treatment is to hasten the death of the patient.

Section 17 then states:

> (2) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use, or to continue to use, life sustaining measures in

treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state.

(3) For the purposes of the law of the State—

(a) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause of death; and

(b) the non-application or discontinuance of life sustaining measures in accordance with subsection (2) does not constitute an intervening cause of death.

Section 18, the saving provision, states:

(1) This act does not authorise the administration of medical treatment for the purpose of causing the death of the person to whom the treatment is administered.

(2) This act does not authorise a person to assist the suicide of another.

I may be wrong and I am not a lawyer, but in reading the Consent to Medical Treatment and Palliative Care Act 1995 I would have thought that there are sufficient safeguards in our current law to protect those in the health profession, especially doctors and specialists, from any criminal liability if someone chose to go down that path. In fact, I repeat section 17(1):

> A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress.

I have witnessed this. I witnessed my father-in-law passing away a couple of years ago, and it was pretty tough; but, at the end of the day, we knew that he was getting the best of care at Ashford Hospital. We were told at the end, and I knew the day I saw him for the last time, that he might have three weeks to live, but I think for his benefit, because he had had enough, he slipped away in the next week and a half.

I still do not condone endorsing euthanasia, because I think the doctors know damn well what they are doing. They know that a side effect of giving treatment may be death and I believe under the current act they are fully protected. I would like to read a letter from the Australian Medical Association of 19 October:

> Dear Politician
>
> Re: Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011
>
> The AMA(SA) remains concerned in regard to the latest amendments by Gardner to the Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011 (proposed by Hon Stephanie Key MP).
>
> The amendments propose that prior to patients receiving 'end of life' treatment that may hasten death they are to be reviewed by two independent specialists, one of whom needs to be a psychiatrist. This is in order to increase the legal defence for a doctor should they face a criminal action. The reason this is seen as necessary of course is that the true underlying purpose of the Bill is the loosening of the present access criteria to effective palliative care to allow patients who do not have a terminal illness to receive treatment that may hasten death. This is seen by the AMA(SA) to amount, on any reasonable objective view, to euthanasia.
>
> The proposal also ironically creates additional barriers to the provision of palliative treatment than presently exist under the current Consent to Medical Treatment and Palliative Care Act. The only logical reason for this increased 'defence' is that the actions and intent of the doctor will become more blurred in the eyes of the public and the legal community, again due to the underlying purpose of the Bill.
>
> The proposed amendments not only present a significant additional burden on patients and the doctors providing care in this area, they are logistically unworkable due to the psychiatric resources in this state. The psychiatric community would also be loath to be involved in such activity given the obvious difficulties of assessment of patients, many who would present with confusion related symptoms. The legal risk upon the psychiatrists as a critical part of the decision making clinical team would also be a deterrent.
>
> The AMA(SA) has previously stated the Bill needs to be debated under its true purpose of allowing euthanasia and clearly differentiated from palliative care. The amendments if accepted will be a deterrent to many doctors being involved in palliative care.
>
> The AMA(SA) supports the principles of patients having access to high quality palliative care. We support the autonomy of doctors to provide this treatment free from the risk of being accused of aiding and assisting suicide, conducting manslaughter, or partaking in any other form of criminal activity where death is hastened as a result of quality palliative treatment. We support the privacy of the patient-doctor relationship and engagement with their families at the time of discussing treatment. We support legislation that supports these principles in the domain of palliative care.

> In summary, this remains a Euthanasia Bill that will damage palliative care in South Australia and the AMA(SA) opposes it.

I support that. I also want to make some comments from a letter that Right to Life Australia has written to me.

> Dear Mr Pederick,
>
> I am writing to you to express my utmost concern at the thought of the S.A. parliament legislating to give to one group in the community—doctors—the power to end life—a power not even possessed by our Supreme Courts!
>
> The Criminal Law Consolidation (Medical Defences—End of Life Arrangements) Amendment Bill 2011 is nothing short of a passport to suicide—physician assisted suicide.
>
> As you must be aware the bill changes the law on homicide to allow a treating doctor to give a deliberate lethal dose to a patient aged 18 years and over where the patient claims to have a medical condition that makes life 'intolerable' for them.
>
> This encompasses a whole range of medical conditions both major and minor. Of particular concern is the category of mental illness.
>
> On the one hand the community demands of governments that more be done for those who are mentally ill, especially those with depression. The level of suicide is alarming especially amongst young men. Interviews with their parents reveal their agony at the loss of a beautiful child to suicide.
>
> Yet here we are preparing to legislate to allow a physician to comply with a request to end the life of someone over 18 years, who may be very depressed or have bipolar disease or schizophrenia or whole range of medical conditions.
>
> To legislate in this fashion is to embrace the principle of the life not worthy to be lived. Why strive to provide good medical treatment for people when they can ask for an early death?
>
> Ultimately, the so-called right to die, if allowed, will ultimately become a duty to die. I urge you to reject the bill.
>
> Yours sincerely, Margaret M. Tighe, Vice President.

I endorse those comments. I have some major concerns that there may be instances, for a whole range of reasons, where people believe their life is not worth living; yet I have heard of various cases where people have been in that very situation and then pulled through with proper medical treatment and lived for quite a few years.

In fact, one of my uncles was a World War II veteran. I got a call that he had been admitted to the Mary Potter Hospice and that he was leaving this world. I thought, 'Poor old uncle Les. He's fought cancer over many years, various forms. And you know what? He came out and he is still alive today,' and that was several months ago. So, tough as he was when he was on the *Shropshire* cooking for the troops. This is a conscience vote. People can vote how they want, but please think about your conscience if you vote for this bill.

Mrs VLAHOS: I move:

Page 2, line 13 [Clause 3, inserted section 13B(1)]—Delete:

> 'or intended death of a person if the death resulted, or was intended to result,' and substitute:
>
> of a person if the death resulted

The Hon. S.W. KEY: I defer to the member for Taylor. I think she needs to explain her amendment. I would like to speak against it, so I would probably like to hear her argument first.

Mrs VLAHOS: Thank you, member for Ashford. I have had a number of ongoing concerns about this bill, but the reason I have tabled these amendments today is that I have sat in the chamber and listened to many of us ponder the nature of this bill. It strikes me that the crux of it is the nature of 'intentional', and that is the thing that troubles many people. So, these amendments are really designed to ensure that the intended consequence of issuing a drug to a person that is suffering from an incurable disease with the primary intent of making that person end their life is dealt with, and that is the crux of these amendments.

That is the crux of these amendments. It is the differentiation between non-intentional, where a drug is issued to someone and a non-intended or secondary consequence is a respiratory arrest or death, which is the current situation in palliative care. The 1995 palliative care act, which the member for Hammond was speaking about before, deals quite adequately with that now in the South Australian

jurisdiction. Where the use of 'intentional' is used in this bill it causes a great many concerns to many general practitioners and palliative care specialists. I do not see a need for this bill to be changed.

The CHAIR: Member for Taylor, I do apologise. I am just making you aware of the time.

Mrs VLAHOS: I will conclude on this first amendment. To sum up, it is about the difference between intentional and non-intentional. I do not support intentional.

Progress reported; committee to sit again.