

## VOLUNTARY ASSISTED DYING BILL 2021

*Legislative Assembly Second Reading Debate – copied from Hansard 12 November 2021*

**Mr JUSTIN CLANCY (Albury) (13:03):** At the outset, we should be clear that this is a Rubicon moment for our State and our society. The Voluntary Assisted Dying Bill 2021 provides State sanction for those involved in the intentional taking of a life. Personally, I have sought to be informed—to read, to research and to listen—to give this matter my full discernment. I acknowledge the diversity of views and have absolute respect for people's experiences of family and friends passing through their end-of-life experience.

I acknowledge our complex human experience and our unending but valuable struggle to seek balance in lawmaking that honours all people as of equal value, all lived experience as meaningful and for our core principles to be worthy pointers to a fairer and safer society. I have met with and spoken with people of faith, and people not of faith, on both sides of this debate. It is not appropriate to deny any person the opportunity to contribute their views, their experience of life, simply because you place a higher value on your position rather than on their position. You can preach from a pulpit or preach from a television program. Influence is everywhere. I adopt the sentiment of Edmund Burke:

Your representative owes you, not his industry only, but his judgement; and he betrays you instead of serving you if he sacrifices it to your opinion.

What is it that has changed in our society in this generation that steers our course in a different direction on a core principle to the generations that preceded us? After all, the mechanisms for effecting the ending of a life have long been available to us. Down the ages, the experiences at end of life are a bond that we share in. We should be under no illusion that an individual's actions do not impact more broadly on society: "No man is an island ...". What is the impact on the individual's first circle of contacts: their family and the medical practitioners around them? How does this reverberate through broader society?

We are in an age where we are endowed with a sense of control. Yet we are constantly reminded by nature that there is much outside of our control. I have seen it proposed that this bill will bring relief, that it will establish a process to assist a person affected by a disease, illness or medical condition that causes suffering to the patient in a way that cannot be totally relieved. A constituent wrote:

The endless suffering must stop not only for the patient but for the loved ones that sit by their side day after day, weeks turning into months and for some of us years.

It is one thing to manage pain; another to manage suffering. Palliative care workers tell me the family member watching a loved one will experience their own personal set of feelings and distress, distinct from the experience of the dying person. They are not the same thing. What is profoundly evident is that individual experiences of family and friends approaching death are compelling and cry out for compassion. Practitioners and professional visitors to palliative care centres are quick to identify where more can be done. For instance, staffing levels may affect the quality of care. One regular hospice visitor said:

The grim almost unspoken reality is that due to staffing levels people are not always surrounded by the appropriate support.

Weak points of current palliative care processes are known. Where it may be redressed through science and funding, we should be seeking to remedy palliative care and make it better. As we explore issues of choice and consent, we should also turn and examine Advanced Care Directives. The document might mention resuscitation, or medications or treatment—broad directions—but then the document might be silent about what should be the steps taken right at the very end of life. Health practitioners tell me they are uncertain about whether those documents are legally enforceable. In an emergency, who has the document? Where can it be found? What does it say? Who bears the risk? One person argues that there is only one person who should be in control. No-one else has the right to impose their views and to this the doctor responds: Is this truly a matter of free choice? Do they have the mental capacity to make that decision? Is there any sense of outside pressure or coercion involved or from within? For some, like another medical practitioner who contacted me, the bill takes our society across a critical threshold. The doctor wrote:

I would like to... discuss my concern, and opposition, to any legislative move to permit physician assisted euthanasia or voluntary assisted dying. It is contrary to the oath I swore when I became a doctor, and is simply bad medical practice. It is not good for patients nor of benefit to our society.

Most of our contemporary debates in Western societies turn on rights and responsibilities. If a government and a society, through its elected representatives for leadership, determines that a situation is to be ruled by principle, then what is to become of a society that abandons that principle when it is faced with a physical or ethical crisis? Are you drawn to supporting your principles as your foundation or to placing them secondary to the individual case of need? If there is one who must be accommodated despite breaching the principle, why not a second example, a third, and so on. Once there is no principle of placing ultimate value on life, there is precious little barrier to it being extended.

In response to Victoria's debate on its voluntary assisted dying bill in 2017, Paul Keating talked of the danger of crossing the threshold we are considering today. He said:

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

I now turn to the bill. I welcome the consideration in the bill for the need to make provision for any health professional or health facility who have a conscientious objection to VAD. But the bill is written from a perspective that does not understand or wish to accommodate conscientious objection as it is understood by those who oppose VAD. Part 5 section 89 states:

A residential facility or health care establishment or may decide that it will not provide services relating to voluntary assisted dying at the facility or establishment.

Nevertheless, despite its objection to involvement, the establishment or facility must, if asked, allow reasonable access by others who will supply information or, it states:

... if the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made ...

Section 97 applies when a permanent resident at a residential facility which does not provide voluntary assisted dying services wants to access that service. Under subsection 97 (2) that facility must allow reasonable access to the person at the facility by the person's administering practitioner for the practitioner to administer a voluntary assisted dying substance to the person or to allow reasonable access to a person lawfully participating as a witness or allow access to a person lawfully delivering a voluntary assisted dying substance to the person. In practical terms, there will need to be a degree of facilitation by people who hold a conscientious objection. I seek an extension of time. [*Extension of time*]

Perhaps because of having previous attempts at drafting a bill and through researching different versions of this type of existing legislation, this bill has become cumbersome when it sets out to be prescriptive. For example, part 4, which covers accessing voluntary assisted dying and death, takes us through six divisions and well over 100 sections and subsections. It carries the hallmarks of trying to balance the need for precision with an abundance of what are ultimately subjective assessments dressed up to appear more objective and clinical than they are. Then we move from parts of the bill that are highly prescriptive to others that are troublingly vague, yet remarkably crucial. Section 27 provides the process to be followed when the coordinating practitioner is unable to decide whether the patient has decision-making capacity, or whether the patient is acting voluntarily and not because of pressure or duress.

Under section 27 (2), in either of those situations the coordinating practitioner must refer the patient to a psychiatrist, another registered health practitioner or a person who has appropriate skills and training to make a decision about the matter. Section 27 (3) states:

If the coordinating practitioner makes a referral under this section, the coordinating practitioner may adopt the decision of the psychiatrist, other registered health practitioner or other person about the matter in relation to which the referral was made.

Let me impress upon members that this is the precise point where we find two of the foremost concerns about this legislation: capacity and consent, and whether that consent is made voluntarily. This is one clause that will enable the process to proceed to its conclusion more readily in a rural or regional area where alternative experts might be hard to find or unwilling to become involved. But it also means adopting a second tier standard for

rural and regional residents. Who chooses this person who has appropriate skills and training? It is the coordinating practitioner. This keeps the process close to home, which can be a good thing. Alternatively, it introduces a fundamental risk.

I have heard a number of problems that people have expressed about the Victorian legislation—that is, there is a lack of specialist doctors in regional Victoria which can lead to a streaming of regional patients to Melbourne for assessment, bringing with it the expected discomfort, stress and delay. The New South Wales bill will, if passed into law, be different in material aspects from the Victorian Act, which differs from the Queensland Act and so on. We are already seeing significant expansion of the reach of VAD in our nation. The general period for availability of VAD has doubled in Queensland's law compared to this bill's section 16 (1) (d) (ii) and pushes out the general period from six months to 12 months life expectancy.

This bill has some conditions for which a 12-month period is specified, but the general period is six months life expectancy. That answers one question for us all—these laws expand their reach and we have not even truly begun to properly accommodate those who live in regional and rural areas for secure and equal processes. For over a year now I have been meeting with palliative care nurses, doctors, pastors, farming families and university students. Correspondence directed to my office in the form of letters, emails and phone calls measures in the hundreds. People took time to do this, so they have clearly placed a high value on expressing their opinions to their local member, which I value. For them, it was not just a tick-the-box exercise. By whatever means it was created or delivered, I interpret all input from my electorate as indicating strongly held but irreconcilable opinions.

Correspondence has not delivered a right answer for my electorate. Respectfully, as a matter of principle, I am not a supporter of voluntary assisted dying legislation and this bill. My view will bring disappointment to many that I serve in my electorate, but relief to many others. If my decision had been the reverse, there would also be people who would be disappointed or relieved. So we stand at this Rubicon. As a society, we should not cross the threshold of the value of life. Living in a multicultural society, I believe this is not so much about living in the past but looking to our future. That is a future where palliative care failings are researched and solved; where cultural differences find an understanding home; where fundamental principles stand, guide and sustain us rather than bend, diminish and ultimately fail us. I do not support the bill.