




Speech By
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MEMBER FOR LOGAN

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VOLUNTARY ASSISTED DYING BILL

 **Mr POWER** (Logan—ALP) (3.38 pm): I rise to speak against the Voluntary Assisted Dying Bill because, in my view of looking at the evidence, it fails to give full protection to the most vulnerable patients at their most vulnerable time. With this bill, there is part of me that would keenly want to be with the majority of my party, but in my party I am not alone, of course. Paul Keating felt so strongly that he wrote a powerful open letter that you all should read that challenges us to consider the deeper meaning of the legislation. Keating wrote—

What matters is the core intention of the law. What matters is the ethical threshold being crossed. What matters is that ... there will be people whose lives we honour and those who believe are better off dead.

Keating further said—

One of the inevitable aspects of debates about euthanasia is the reluctance on the part of advocates to confront the essence of what they propose.

Before we vote, let us accept Keating's challenge and directly confront what we are doing here today. He defined it as—

It means permitting physicians to intentionally kill patients or assisting patients in killing themselves.

It is of course extraordinary to take such a drastic policy action to seek to end the lives of Queensland citizens, even if they have been diagnosed with a terminal illness. If we are to take such a step then it must be for an extraordinary reason.

As many in this place know, I sought out as many advocates for euthanasia as I could, including Andrew Denton—taking his advice to listen to his podcast. In that podcast he played the recording of his father, Kit, in 1986—11 years before he died—where he called for euthanasia by defining it as 'it means not dying in a screaming welter of pain'. We all agree that this was our original policy goal—to end traumatic, painful, bad deaths. However, looking at the evidence, I am not convinced that this version of VAD is dedicated to achieving that goal.

It is not just me saying this. White and Willmott, in the University of New South Wales Law Journal, agreed when reviewing the Victorian act, which is very similar. They stated about alleviating human suffering—

Compassion was a significant driver at the macro policy level ...

They go on—

This policy goal aims to alleviate the suffering of individuals at the end of their lives. However, as the Panel shifted to operationalise its recommendations, compassion appeared to assume a less significant role.

They continue—

This may indicate that compassion—

for suffering during death—

played an important role in deciding whether or not to enact a VAD law, but then had less influence on the shape of that law ...

I asked advocates of euthanasia VAD laws what percentage of people might take up the law. Professor White said that from the evidence in Oregon it would stabilise at one-third of one per cent. If this percentage of people were facing death in a 'screaming welter of pain' then that would go at least a small way to meeting the goal we set out to achieve. However, I asked oncologists and palliative care experts if they could predict 12 or six months out if a patient was likely to face a bad death. They clearly said to me that, with all their experience of hundreds of patient deaths, they could not predict this. Palliative care specialists said that with good care these deaths are also very rare. Instead of asking those who spend their lives helping those who are facing death, this legislation places the burden of this decision up to 12 months out on a patient who has almost always never experienced the progress of the terminal illness they have.

I recently spoke with a wonderful woman in Park Ridge who took it to me. She thought I had it wrong. She told me that she intended to ask for euthanasia when she got a terminal diagnosis, but she was bright and healthy when I spoke to her. I asked her why and she said that she had lived through the trauma of an aunt dying over 60 years ago. I know that there have been enormous and ongoing improvements in palliative care in that 60 years.

I fear that all of this information may not be part of her decision. I fear that a patient may be given and act upon incorrect information about the time frame of their terminal diagnosis. Specialists have told me that doctors are trained primarily to cure disease and they are not trained to predict survival. They are not able to accurately predict if someone could die within the next 12 months. In the case of cancer patients, 10 to 15 per cent of the time a patient will live three times longer than the predicted best estimate. Not only is the patient not clear about what pain they will face at the end of life; they may also live far longer than was predicted.

Further, doctors can sometimes give patients the wrong information about a diagnosis. A specialist told me, 'Diseases are hard to predict and doctors can make dramatic mistakes.' This doctor bravely spoke of his own failings of misdiagnosing a patient with a lung condition as a terminal condition and the patient being unable to walk because of the wrong treatment and misdiagnosis. Time luckily gave the doctor the chance to realise his mistake and 13 years later this patient still lives a rich life. This is not unique. Every doctor makes serious mistakes because diagnosis and treatment is an imperfect science. How many Queenslanders will, based on this misinformation, start the VAD process, be facing pain and take their own life? The truth is probably not many—partly because so few Queenslanders will take this choice. We know that, if we pass this bill, then it will happen.

If we give the patient the wrong information or there is great uncertainty about prognosis, we fail to give patients what they need to make such an important and irreversible decision. If the people making the decision to access VAD laws were already experiencing unmanageable pain—and some of them will—then the patient would have much more knowledge of the progress of their illness. However, under similar laws in Victoria the evidence is that people were not accessing VAD because of any unmanageable pain but instead for other reasons. In one survey, 36 out of 37 people said they were not experiencing any unmanageable pain.

Quotes from those accessing the Victorian VAD drugs in an article in the *Australian* gave us reasons for accessing the drugs and beginning the journey to end their lives: 'I want to be in control'; 'It's an insurance policy and I may never cash it in, but it is there if I need it'; so that family can 'remember me as I am, not as I will be if things get worse'. The *Weekend Australian* summed up why people are accessing the system—

Rather than unmanageable pain the impetus for those accessing the law ... is usually what doctors term 'existential suffering'. As people lose function, independence and joy, they yearn above all for a sense of control.

These are really important things, but let us be clear that this is not the reason we started on the journey to make this extraordinary policy. We have heard from experts—none less than the member for Greenslopes—that with good care we can treat some of those feelings.

I recognise that individuals do not immediately end their lives and only they know how they experience their personal terminal illness. I find this a genuine conflict and recognise that for many on both sides this personal decision during this period is enough for them. We also know that patients facing a terminal diagnosis can be some of the most vulnerable Queenslanders. We as Labor people—much more than the conservative side of politics—understand that we do not and cannot design laws for an ideal citizen with perfect information. My father taught me that Labor people instinctively understand that the law is not equal for those whose lives have been damaged by poverty, abuse and fear of our institutions, even our medical institutions.

Keating in his letter reminds us that between two and 10 per cent of older Australians experience abuse in any given year. The bill recognises that abuse will happen. In the first assessment there is a tick box for doctors to assert that the person seeking end of life does so without pressure from others,

but there is no standard. We know that doctors can be treating patients for years and not learn of the horrendous elder abuse they suffer. That is not the fault of the doctors. However, this act expects the doctor assessing the eligibility criteria to make this judgement instantly, often meeting the patient for the first time as they make the assessment.

We could design a different bill that ensured patients had better information, better support through psychological support and through understanding of the process they face. However, this is not this bill. Honestly, after looking at all the evidence, I am not sure that, with so few people facing terminal diagnosis taking up this option and the disconnect between that decision and profoundly bad deaths, any VAD law would fulfil the objective we had set ourselves.

Having listened to this debate, I can see that this bill will pass the House. However, we should not forget that we have much more to do to empower those diagnosed with a terminal condition through advance health directives, great palliative care and importantly a focus not just on what the disease will do to the patient but what great things the patient can do in the valuable time they have left. I listened to Andrew Denton's podcast and an interview with Dr Roger Hunt, who said of palliative care—

Good things can happen, perhaps restoring relationships, maybe estranged family members come into the scene, the love and care that can be provided in a hospice can brighten a lonely person's existence. I've heard some people say these have been the best days of my life ... but bad things can happen in those days as well.

It is our continuous job, especially after the passage of this legislation, to ensure that palliative care is the best that it can be. If we had asked those people who told Dr Hunt in their final days of palliative care, although disabling and difficult and uncomfortable, that their final days were 'the best days of my life', they would not have anticipated this. They undoubtedly would not. This is what makes a patient's decision so difficult, if not impossible. Together let us not take this extreme option that does not eliminate pain, but instead create great palliative care for Queensland.