HOUSE OF ASSEMBLY

TUESDAY 15TH NOVEMBER 2016

DEATH WITH DIGNITY BILL

Second Reading

Adjourned debate on second reading.

(Continued from 3 November 2016.)

Mr PEDERICK (Hammond) (20:02): I rise to speak to the Death with Dignity Bill 2016. It may come as no surprise that I will not be supporting the bill, which is a consistent stand I have taken for the whole time I have been in this place in regard to so-called voluntary euthanasia. I note that this bill is, I think, the 15th attempt in this parliament to legalise voluntary euthanasia, and I am a bit—

Members interjecting:

The DEPUTY SPEAKER: Order! There is too much noise in this chamber. I cannot hear the member for Hammond.

Mr PEDERICK: Thank you for your protection, Deputy Speaker.

The DEPUTY SPEAKER: I will always protect you, member for Hammond.

Mr PEDERICK: Thank you. What concerns me is that there have been so many attempts, yet the proponents of voluntary euthanasia do not seem to get it anywhere near right. I still do not think we are there by any manner of means and I will not be supporting the bill. I want to talk about some correspondence received from FamilyVoice Australia in relation to the bill, talking about what they believe are serious flaws in the Death with Dignity Bill 2016.

When the member for Morphett introduced this bill, he said that it had all the safeguards that he observed were missing from the member for Ashford's Voluntary Euthanasia Bill 2016. However, an examination of the bill reveals that it lacks very important safeguards. If passed, it would open the door to serious abuse of vulnerable people, who deserve protection. Some of the bill's flaws are outlined below, and I am quoting from a letter from FamilyVoice Australia:

Since most are fundamental parts of the legislation, the Bill cannot be improved by amendment during the committee stage. It should be rejected on principle at the second reading.

In regard to clause 8—No offence to provide information etc about voluntary euthanasia:

Despite section 13A of the Criminal Law Consolidation Act 1935, or any other Act or law, a person incurs no criminal or civil liability merely by providing or publishing information relating to voluntary euthanasia; or selling or supplying material or equipment (not being a drug) that is, or is to be, used for a purpose relating to voluntary euthanasia.

Note

Section 13A of the Criminal Law Consolidation Act 1935 makes it an offence to aid, abet or counsel the suicide or attempted suicide of another.

This clause would legalise 'workshops' (such as those conducted by Dr Philip Nitschke) advising people of any age about methods they can use to commit suicide (that is, 'self-administer

voluntary euthanasia' in the words of Division 3 of the Bill). Clause 8 would also legalise the sale of canisters of lethal gas and other equipment for suicidal purposes. None of the alleged safeguards in the Bill (such as the requirement that the person be of sound mind and have a terminal illness) would apply to people attending such events or buying such equipment. This clause has the potential to facilitate the suicide of temporarily depressed young people or others who are similarly vulnerable.

Section 9 Who may make a request for voluntary euthanasia

(4)(d)the question of whether a person's suffering is intolerable—

(i) is to be determined subjectively and need not meet an objective standard; and

(ii) cannot be challenged or questioned in any proceedings seeking to prevent or delay the administration of voluntary euthanasia to the person;

Since the person's claim to be suffering intolerably from an illness or treatment cannot be challenged, the bill is effectively endorsing suicide, and the 'intolerable' requirement is meaningless.

Section 9(4)(e)

in determining whether a person's death has become inevitable, it is not necessary to establish that the death is imminent nor that it will occur within a particular period.

A person could have a terminal illness such as heart disease that could kill them years down the track, but could seek euthanasia immediately if he or she subjectively claims to be suffering intolerably.

Section 11 Preliminary examination and assessment by medical practitioner

(2) If the medical practitioner reasonably suspects that—

(a) the person is not of sound mind; or

(b) the decision making ability of the person is adversely affected by their state of mind; or

(c) the person is acting under any form of duress, inducement or undue influence (including that due solely to a perception or mistake on the part of the person) in relation to their wish to request voluntary euthanasia,

the medical practitioner must refer the person to a psychiatrist for examination and assessment in accordance with section 13.

Psychiatrists are not necessarily competent to detect whether a person is adversely affected by their state of mind or acting under duress: GPs even less so. Dr David Kissane, Professor of Psychiatry at Monash University, said in a letter to SA MPs, dated 26/10/16:

'A psychiatric gate-keeping role within legislation for euthanasia does not work effectively. For example, the ROTI legislation in Darwin failed in this regard. I studied Dr Phillip Nitschke's medical records with his permission, tape-recorded research interviews with him, and reviewed the files held by the NT Coroner's Court. Together, we published these case reports in the Lancet in 1998. Pain control and symptom management was poor. Clinical depression was ignored by some psychiatrists reviewing these patients. One patient on low doses of antidepressants did not have this increased or the medication changed.These clinicians did not have the subspecialty skills within psychiatry to recognise and intervene with these patients and their families.'

Section 16 Self-administration of voluntary euthanasia:

(2) A person self-administering voluntary euthanasia may be assisted by such other persons as he or she thinks fit.

This clause would allow an acquaintance, relative or heir of a person approved for voluntary euthanasia to administer a lethal dose to the person. But no one would know if the person had earlier orally revoked the euthanasia request. If the lethal dose was administered despite the revocation, the key witness would be dead. This clause could facilitate murder in some cases.

Section 21 Cause of death:

(1) For the purposes of the law of the State the death of a person resulting from the administration of voluntary euthanasia—

(a) will be taken to have been caused by the terminal medical condition from which the person was suffering (being the terminal medical condition referred to in section 9(2)(b)); and

(b) will be taken not to be suicide or homicide.

I think there are some real concerns, and the letter goes on. I am running out of time, but I want to talk about what has happened overseas where euthanasia has been legalised. In Belgium, in 2003, the number of people going through euthanasia was 235 and in 2015 it was 2,012; in the Netherlands, in 2008, it was 2,331 and in 2015 it was 5,516; in Switzerland, in 1998, it was 50 and in 2014 it was 836; in Oregon, in 1998, it was 16 and in 2015 it was 132; in Washington State, in 2009, it was 64 and in 2014 it was 170.

They are some of the reasons, but not all of the reasons. I have a swag of other correspondence from people concerned about this bill, this legislation. A family lost a son overseas when he accessed some of Dr Philip Nitschke's equipment and suicided because he was depressed. I have real concerns about this. I think we need to respect life, respect palliative care and what it does to help people during their latter time in life. Therefore, I will not be supporting the bill.