



# ***HEALTH AND ENVIRONMENT COMMITTEE***

**Members present:**

Mr AD Harper MP—Chair  
Mr SSJ Andrew MP  
Ms AB King MP  
Mr R Molhoek MP  
Ms JE Pease MP  
Dr MA Robinson MP

**Visiting Member:**

Mr MC Berkman MP

**Staff present:**

Dr J Dewar—Committee Secretary

## **PUBLIC HEARING—INQUIRY INTO THE VOLUNTARY ASSISTED DYING BILL 2021**

### **TRANSCRIPT OF PROCEEDINGS**

**TUESDAY, 13 JULY 2021**

**Rockhampton**

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### **The committee met at 1.01 pm.**

**CHAIR:** Good afternoon. Thank you very much for coming to the Health and Environment Committee's public hearing on the Voluntary Assisted Dying Bill 2021. I would like to first acknowledge the traditional owners of the land upon which we meet today to discuss this business and pay my respects to elders past, present and emerging. It is incredibly important that we continue to acknowledge and recognise two of the world's oldest continuous living cultures in Aboriginal and Torres Strait Islander peoples.

I would like to introduce the members of the committee. I am Aaron Harper, member for Thuringowa and chair of the committee. Mr Rob Molhoek, member for Southport, is the deputy chair. The other committee members are: Mr Stephen Andrew, member for Mirani; Ms Ali King, member for Pumicestone; Ms Joan Pease, member for Lytton; and Dr Mark Robinson, member for Oodgeroo. Joining us today is Mr Michael Berkman, member for Maiwar, who is visiting and was a member of the former health committee during its inquiry into the views of Queenslanders on this issue. People here from Brisbane and Townsville are still wearing masks. It is not that we do not want to smile at you; it is just that we are still at that point in time. I believe we will be able to take them off at 6 am on Friday. People from South-East Queensland will continue to wear masks until then.

To put this in perspective, the former health committee established a very broad-ranging inquiry in 2018 on the issue of aged care, palliative care, end-of-life care and voluntary assisted dying. That resulted in a tabled report recommending that a bill be drafted, and that is what is before us today. The Queensland Law Reform Commission has put the legal framework around that, and we are asking people today about their views on the bill. We have certainly heard from Queenslanders about their views on voluntary assisted dying, but we really appreciate people's views on the bill itself. That being said, there are quite a number of people from the public here. If you would like to speak on the issue of voluntary assisted dying after the registered speakers today, we will get you to register with Jacqui from the secretariat and we will call you up as the afternoon progresses.

### **RICHARDS, Mr Stephen, Board Member, Fitzroy Community Hospice**

### **RYAN, Ms Paula, Board Member, Fitzroy Community Hospice**

### **THOMPSON, Mr Mark, Board Member, Fitzroy Community Hospice**

**CHAIR:** I welcome representatives from the Fitzroy Community Hospice. Would you like to make an opening statement before we move to questions?

**Mr Richards:** Thank you for this opportunity to address the committee today and express our views. We are representatives of board members of the Fitzroy Community Hospice, which is a not-for-profit charitable organisation that is committed to the establishment of CQ's first hospice. Fitzroy Community Hospice will address the needs for community based palliative care in our communities by operating a 12-bed hospice facility near the Rockhampton Base Hospital and by providing dedicated in-home palliative care services.

Our primary concern with the VAD legislation as proposed is that the core principles of voluntary assisted dying in clause 5 are not being met. We see the core principles as the foundation for the whole legislation. I will quote the clauses. Clause 5(d) states—

... every person approaching the end of life should be provided with high quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life—

The second clause that we believe is not being met is 5(e), which states—

... access to voluntary assisted dying and other end of life choices should be available regardless of where a person lives in Queensland.

That particularly applies to regional, rural and remote areas. As this health committee has previously acknowledged, access to high-quality palliative care and end-of-life choices is not currently available to all people living throughout Queensland, and here in CQ it is no different. This includes access to hospice care, which is inequitably distributed throughout Queensland, with all hospices currently located in the south-east corner.

It is noted that this health committee submitted report No. 33 titled *Aged care, end-of-life and palliative care* on 24 March and it contained quite a number of recommendations. We as a board are trying to address some of those recommendations. Recommendation No. 48 relates to assistance for regional hospices and states—

The committee recommends that the Queensland Government with assistance from Primary Health Networks examine ways to help establish viable hospices outside of South East Queensland.

The other recommendations we will address are: No. 47, assistance for people wishing to die at home; No. 50, after-hours palliative care; No. 65, respite care for informal carers; and No. 66, palliative care community education strategy. We have seen no evidence that these recommendations have been translated into action, and it is our view that the current allocation of funding is insufficient to achieve this.

The current state palliative care sector budget is \$110 million per year, which is around half a per cent of the total annual state health budget. The Queensland Treasurer announced in the 2021-22 budget an increase of funding of \$171 million over a future six years. This increase equates to only \$29 million per year, of which a tiny \$9 million per year has been allocated to fund new community based services such as the Fitzroy Community Hospice. Remember that the state annual health budget is \$22 billion a year. It is our view that that \$9 million per year is grossly insufficient to establish and operate multiple viable hospices outside the south-east corner; nor is an extra \$28 million a year enough to achieve the equitable access to excellent palliative care that is promoted as a core principle of the VAD Bill that we are discussing today.

In Queensland, a person's choice to explore voluntary assisted dying should never be based on a lack of access to palliative care; however, we fear that limited funding and access, as well as equity issues, could make this the case. We implore you as the parliamentary committee to make specific recommendations to the government to ensure alignment with the principles in clause 5 that every person approaching end of life should be provided with high-quality care and treatment, including palliative care, to minimise the person's suffering and maximise the person's quality of life.

It is our view that increased care funding is critical and needs to be mandated. This will require an additional \$247 million per year for a total annual budget of \$275 million per year, as quoted by the AMA. VAD is based solely on choice, so we conclude our submission by saying that true choice—and I emphasise the word 'true'—at end of life must include excellent palliative care.

**CHAIR:** Thank you very much for your opening statement. I have some figures here and, yes, you are correct: there are a number of members who were on the previous committee who made those recommendations to increase funding. There was an announcement by the Premier of \$170 million in September 2020. We did ask the department two weeks ago what that will look like. We are advised that the new funding will take the total to \$247 million in the 2024-25 financial year.

Funding for palliative care aside, I want to get down to the crux—and I can see where you are linking palliative care and the clause. I want to get your view on two things. I commend the community for getting behind this hospice. I understand you have succeeded in getting \$9 million in funding allocated. You mentioned \$9 million for your hospice. Can you just clarify that? Is the cost of the community hospice \$9 million?

**Mr Richards:** The cost of a hospice is over \$11 million. Obviously, at this moment we are lobbying quite strenuously our governments in terms of funding for that.

**CHAIR:** I commend the organisation for doing this, because we heard when we were here that that was the aim and desire to get that hospice up and running. When and if this bill is passed, will your hospice allow practitioners to deliver voluntary assisted dying in that facility? That is the first question.

**Ms Ryan:** Thank you for that question. At this stage, I think for the hospice we are a community based organisation—we are not operational—and we would be consulting with our GPs and our community on what that would look like for the hospice. It would not be part of my remit to actually say, 'Yes, we would do it,' or 'No, we would not.' As a registered nurse with 40 years in health and 35 years in cancer and specialist palliative care services I have my own views, but that would be the hospice's position.

**CHAIR:** From one health professional to another, thank you for sharing that with people. The other part is access, and you mentioned access and equity for people in rural, remote and regional Queensland. Coming from North Queensland, we certainly heard that and we made some recommendations in that report. The issue of telehealth was raised yesterday. What are your views on the clause in the bill that talks about being able to provide information on voluntary assisted dying

using telehealth services to deliver that when you might not have a specialist and you might only have one GP in a town? There is a Commonwealth carriage service law that has been flagged by the Queensland Law Reform Commission in its report. What are your views on people in Far North Queensland or Central Queensland being able to use that telehealth service to access information or the process of voluntary assisted dying should the bill be passed?

**Ms Ryan:** Again, thank for the question. There will be a multifactorial answer coming from me, I suppose, so bear with me. Telehealth in itself is a fabulous initiative. When we are talking about that, though, we have to put it in the framework of a palliative care network. What worries me is that over the years people seem to think telehealth is the panacea for everything. It is not. It is part of the treatment delivery model. The short answer is, yes, telehealth needs to be used but, added to that—this is my experience—is that when people are sent home to rural and remote areas and regional areas, the burden on the carers and the patient is immense because of the lack of networked services in those regions. The communities can look after these people very well, but they need the education and the backup. We need to have a robust framework in Queensland that can deliver that. At the moment, we do not have it; it is completely fragmented. To deliver good palliative care, of which VAD is an element—there is two to three per cent of the population that will request VAD, but if we are not providing coordinated, integrated care across Queensland we are failing. We are failing our patients and families badly. Telehealth certainly will support GPs in particular and the community and the nurses. As you can see, it is such a complex picture but, after 40 years, I can tell you it is doable. We have just not done it.

**Mr MOLHOEK:** I want to add my thanks to you and your committee, Stephen, for the work that you are doing in this space. My question is to Paula as a health professional of some 40 years. Can you speak more broadly about what palliative care services are available now within the Rockhampton-Fitzroy region, perhaps about what some of the challenges have been in securing trained doctors and specialists to work in that place and about the sort of coverage the Central health district or the Rockhampton district has to cater for in terms of geography?

**Ms Ryan:** I will speak of it as someone who used to work for CQHHS. I was the nurse unit manager of cancer and specialist palliative care services. The first thing I will say is that the fragmentation of services throughout Central Queensland is not due to a lack of will from communities and professionals. It often has boiled down to, 'We have not got the money,' and that has been said to me in a professional capacity year after year after year. That sets the framework. Getting health professionals like palliative care specialists to work in the area—we have one at the moment. Again, we are being told there is no money. That has been a huge stumbling block.

In terms of an overview of the framework in Central Queensland, I will start with the government sector. We have operating out of Rockhampton Hospital a specialist palliative care service which does a great job, and all these people in Central Queensland do a great job. They have a community liaison service that has 1.4 FTE of clinical nurse. That is it. That is supposed to cover a seven-day service. It cannot provide 24 hours, seven days a week. Those of you who understand nursing rosters will know that 1.4 FTE does not really cut it. That service is really built on the MacMillan model out of the UK. You still have Blue Care and AusCare doing generalist palliative care, but the specialist palliative care come in to consult on really complex issues.

With that amount of staffing, that service has not even reached the tip of the iceberg with chronic palliative care disease. It is mainly for malignancies. We do not have the people on the ground to deliver it. That service also works out of Capricorn Coast Hospital and Mount Morgan Hospital and then has some networking links with Biloela, Gladstone and Emerald. Again, there is not the dedicated staffing. What we really need is that dedicated hub-and-spoke model, and that is not there. The spokes are not there for those reasons that I spoke of.

Privately, we basically have GPs who work more in the generalist sphere. We have no private palliative care specialists. In the private sector it is physicians who have an interest. They will take on some complex private patients, but often then they will ring the palliative care specialist at Rockhampton Hospital and there is a consultation there of what is going on. As you can see, it is not robust. It is not particularly coordinated. That is not from lack of will of everyone on the ground. I hope that answers your question.

**Mr MOLHOEK:** Just to clarify one point, you mentioned there is 1.4 FTE to look after the palliative care unit.

**Ms Ryan:** The community service.

**Mr MOLHOEK:** Is that 1.4 just for Rockhampton, or do they cover Mount Morgan, Biloela, Emerald?

**Ms Ryan:** They cover Capricorn Coast. There is not enough to do Mount Morgan regularly. Occasionally they will get up there. As you can see, it is stretched very thinly. At Rockhampton Hospital there is a cancer inpatient unit which has five specialist palliative care beds that can be used for admissions and end-of-life care. That unit currently is getting swallowed up in the ramping crisis and the bed crisis, so we now have acute care patients being admitted to beds. When the bed is full—you want your mother admitted because you are exhausted from caring—you will get stuck in the ED cycle. Speaking personally, I had a dear family friend a week ago spend two days dying of breast cancer in the emergency department. It was great care and caring people, but she needed a bed in a dedicated unit and it was not there. That is because the beds are not quarantined. Then you end up with wrong people in wrong beds with not the right care intent.

**Ms KING:** We are enormously lucky to have the collective knowledge of your group here today to inform us about the situation here in Central Queensland. I do know from my own previous work experience how much effort goes into trying to set up a community hospice service, so thank you for what you are doing to make that happen.

I briefly want to note that it can be very difficult to assess funding that goes into palliative care at any given point in time. The department recently advised us that currently it is at \$149 million a year. With additional funding that has been announced, by 2024-25 it is going to be at \$247 million a year, but I recognise that there is a huge amount of need—there is no question about that—particularly for getting services into your communities.

Ms Ryan, you mentioned that a certain proportion of people would always want to access voluntary assisted dying. Could you comment on whether, with the best possible palliative care, in your view, some people will always seek or wish to access voluntary assisted dying at the end of their illness journey?

**Ms Ryan:** In my experience, yes. I have had patients have that discussion with me over the years. That is a reasonable thing. What I philosophically object to is that, as a community and our governments, we are failing because we have a system that is allowing people to feel hopeless and helpless because we are not providing them with a comprehensive, excellent palliative care service in this state. Think about it: if you are hopeless and helpless and your family is not being supported and the carer is falling apart because they are so exhausted—I would want voluntary assisted dying, but is it not better that we give them the choice?

Last week I sat with a man whose wife has been dying for two years with chronic obstructive airways disease. She is now at the pointy end. He looked at me and he said, 'You know, this is really tough.' I said, 'Yep, it is.' He said, 'It's really tough.' I said, 'Yes, it is.' He said, 'You know what? I would not have missed this for the world.' At that I started to cry and he started to cry and he said, 'She has laughed more, we have talked more, and I'm pleased I've had the time.' That was their choice. We do not have the system to support an integrated framework.

**Ms KING:** Taking you to the provisions of the bill before us, if it is implemented do you believe that the way this bill will work is safe, compassionate and accessible in practice?

**Ms Ryan:** That is a tough question. I would want to make sure there are some very secure safeguards around this bill, because it worries me that it can be seen by people whose intentions are not always honourable as expediency rather than informed choice.

**CHAIR:** Just picking up on your response, yesterday we heard from Dr Will Cairns, who is at the Townsville oncology and palliative care unit and at the Sunshine Coast. He has had around 40 years of practice and he estimated that he has looked after 7,000 to 10,000 people at their end of life. It was his view yesterday that, even with the best palliative care available, you cannot relieve all pain and suffering all of the time to everyone. He was a believer that people should have choice. I think it goes back to that choice area, but do you have any views in your experience of that?

**Ms Ryan:** I know Will. I have worked with Will. He is right: there is a small percentage. You will get these intractable pain syndromes, and they are very tricky. People will be asking. That is a choice. They get the choice. That is really important.

**Dr ROBINSON:** With the indulgence of the committee, it is wonderful to be back in Rockhampton. A lot of good things come out of Rockhampton. I have a wonderful wife that came out of Rockhampton. I have to confess to being a Victorian, but I am told that I am redeemed because I have a Rockhampton wife, so I am going to go with that. We are celebrating a great Rockhampton person, 'Rocket' Rod Laver, just a few days ago celebrating the 60th anniversary of his first Wimbledon win, so a lot of good stuff comes out of Rocky—paying my tribute to the Rocky gods.

In terms of VAD legislation, there are a lot of different questions I could ask you, but in terms of the context of the day and the time we have, do you see that there are—I will be up-front; I am not a fan of VAD. I believe that there are better ways to provide the relief of suffering for those who are dying. I have great concerns about the legislation. Are there potentials in this legislation that could impede or be unhelpful in terms of providing end-of-life care here in Rockhampton and in this broader area when we think of not only government—public funding, public programs and public facilities—but also private facilities? We know that there are various church groups. We know that there are other community groups in this space in terms of hospital care and aged care. Are there problems that this legislation could provide for us trying to expand significantly end-of-life treatment in this region? I concur with what you have said in that the long-term underfunding in this whole sector has caused problems. Where do you see that sitting in terms of this VAD legislation?

**Ms Ryan:** I will put it in the context of a case history—very briefly, because we do not have much time. I will be quick. Let's suppose that a woman is diagnosed with a very nasty abdominal stomach cancer—it is nasty. The surgeon says to her husband, 'Six months if you are lucky.' She says, 'God, okay,' but she has a different viewpoint on life. This is based on reality. She decides to get an early referral to a palliative care physician here in this town. She does so and the symptoms are sorted. She is on good analgesia, minimal doses, because that is all that was needed at that stage, and she starts to live her life with her palliative disease. She gets to travel, she goes overseas, she has good family connections, parties—you name it. Instead of six months of life, she dies 2½ years later. She did think about VAD. She chose not to because her symptoms were well controlled, her carer was being supported and she could have a life. That was done on the goodwill of a lot of health professionals because there was nothing much back then. In answer to the question, VAD could throw a light that funding is not directed where it needs to be to provide excellence in palliative care. I hope that answers what you are after.

**Dr ROBINSON:** It was a wideranging question.

**Ms Ryan:** It was.

**Dr ROBINSON:** Thank you for your answer. One quick follow-up question, and it is a question I have been trying to understand from Queensland Health in terms of how we fund both palliative care and potentially VAD treatment at the same time. I am not aware of costings of the VAD program going forward. I am assuming it must be modelled. Is there the potential that once the numbers of those accessing VAD increases—and we are seeing in parts of Europe, Canada and the United States, in some places, many thousands of people accessing VAD now—that could take funding away from already scant palliative care resources?

**Ms Ryan:** My reply is: why would we have two buckets of money, one for palliative care and one for VAD? In my head, isn't the main banner palliative care services for Queensland of which VAD is a component, accessible as needed after enacting comprehensive palliative care services? To me, I would not be thinking VAD gets X amount of dollars and that is a separate bucket. To me, we fund comprehensive palliative care services for all the community and VAD is an option that can be discussed as needed.

**CHAIR:** Member, to clarify, the Queensland Law Reform Commission and the review board created separate clauses for starting the palliative care navigation system. I think they will be funded completely separately from the money that was announced for palliative care if the legislation is passed, so we have a bit of a step.

**Ms PEASE:** Thank you to the board of the Fitzroy Community Hospice for coming in and thank you for your passion and dedication. It is great to be a community worker. I have worked in the community and I see the great value and great rewards it can bring not just to yourselves but also to your entire community. Thank you.

Yesterday we were in Townsville and we heard from Dr Heather McNamee, who spoke about her patients who are currently at end of life. She is a GP with over 28 years of working in that sector. She does house visits. She cares for people at end of life and, like many GPs, has the privilege of taking care of patients from the beginning of life, sees them raise their families and the kids growing up and then sees them at the end of life. It is a real privilege, like it was for me with my parents when they passed away. It is a real privilege. You spoke of your friend. I share your views with that, that it is a real privilege to be with people at the end of life and help them on the journey and decisions that they have made. Dr McNamee spoke about how, more often than not, currently people who are in intolerable pain are getting sedated under palliative care and are passing away once they have been sedated. As a consequence, potentially this is an unregulated form of voluntary assisted dying. Do you have any comments on that?

**Ms Ryan:** I understand what Dr McNamee is talking about. My experience, though, has been that (a) the population of people with severe intractable pain syndromes is very small and (b) and I have given lots and lots and lots of drugs and syringe drivers, but I could always back that up in my specialists and GPs with why we were doing what we were doing; we were treating the symptoms of end-of-life care. I think you are drawing a very fine line there. Hand on heart, I can tell you that it would have been my experience that it was always for a symptom of end-of-life care.

**Ms PEASE:** Further to that then, perhaps you might like to comment on the fact that with palliative sedation, is there not always going to be a particular outcome of that palliative sedation and that outcome is death?

**Ms Ryan:** Sedation is used for—I do not particularly like the term—terminal agitation and restlessness, and it is very necessary to smooth the waters because it is quite distressing for the patient to feel this terminal agitation restlessness. The sedation is used to keep them calm and then the natural process is that they then will progress to death. It is not done, though, at doses that will kill them instantly. They are usually doses that are quite small and increased if the agitation increases—we tend to be treating the symptoms—but I get what you are saying.

**Ms PEASE:** At what point does a patient have the opportunity to say, 'I want that sedation to help me,' to relieve those symptoms?

**Ms Ryan:** In the ideal world, with an integrated palliative care service, advance health plans need to be done early in the diagnosis of a palliative disease. In that, the discussions are had with the family and the patient on how you want this to look. That is when people can actually be flagging what their choices are: 'Do you want to die at home?' 'No, I don't.' 'Do you want to use hospital?' Voluntary assisted dying, as I said, could be part of that, but that person has the choice then, and that plan guides the care they get at end of life.

**Ms PEASE:** Are you familiar with the piece of legislation that is before us about the processes involved in people making inquiries about voluntary assisted dying?

**Ms Ryan:** Can you give me some clarification of what you are after there?

**Ms PEASE:** At the moment, an advance health directive would not be appropriate because we have to be able to determine the capacity of the person who is requesting and it has to be up to that person to make that request.

**Ms Ryan:** Yes.

**Ms PEASE:** My point is that there are a great many more protections for the patient with voluntary assisted dying legislation that we are here discussing today to make sure their wishes are being met at a time when they have the capacity to make those decisions.

**Ms Ryan:** I was not talking about advance health directive; I was talking about advance care planning. I get what you are saying, but care planning is about how you want your death to look.

**Ms PEASE:** Most certainly, but there is a very big difference between an unregulated situation with the advance planning and a voluntary assisted dying request which has to go through a number of different checks. There are three different opportunities for them to say.

**Ms Ryan:** All the checks, yes.

**Ms PEASE:** Would that regulation not give more comfort to family members and to the person involved because they get the opportunity to make that decision themselves?

**Ms Ryan:** It is about choice and making their decision, yes.

**Mr ANDREW:** Thank you to the board for coming here today. We have spoken in the past and I plan to catch up with you very soon. You spoke earlier about the spokes in the wheels and everything together. Do we have that framework?

**Ms Ryan:** A big no.

**Mr ANDREW:** Anywhere in Queensland?

**Ms Ryan:** I have to think. It is a bit rudimentary out of Townsville perhaps. I am not in touch with Townsville these days. We do not have a properly funded hub-and-spoke model throughout Queensland. We have tenuous links with rural and remote communities, but a proper hub-and-spoke has proper formal networked agencies in it and proper ways of operating so that the hub-and-spoke model does not collapse. At the moment we rely on the goodwill of the rural and remote communities, and they rely on our goodwill as well.

**CHAIR:** To the board members from Fitzroy Community Hospice, we thank you very much for your contribution today.

**SANDFORD, Prof. Alan AM, Director, Medical Academic Development, Central Queensland and Wide Bay Hospital and Health Service**

**CHAIR:** Good afternoon, Professor. Would you like to begin by making an opening statement? Then we will move on to questions.

**Prof. Sandford:** I am actually wearing a number of hats. It may be of interest to committee members to know exactly whom I represent at this point in time. I am currently acting as the executive director of medical services in Central Queensland. I am a specialist medical administrator in one of the 15 speciality colleges. I also happen to be president of the Royal Australasian College of Medical Administrators, and I will be appearing before this committee on Thursday in Brisbane. I must further emphasise that I am not representing myself. I actually have a body of different constituents, as it were, whom I represent.

I have been following the legislation and discussion on this issue before the Queensland people—but also across the nation—with great interest. Firstly, the Royal Australasian College of Medical Administrators—and as a medical leader—has no specific position on the legislation or the matter of voluntary assisted dying. The position I would like to put forward to you is that, as medical leaders, we are very much involved in matters surrounding this matter. As medical leaders, we are required to protect quality, safety and system integrity within our domains, and that is across public and private communities. Members of my college and medical leaders in that domain have that responsibility. There is no question about the importance and value of palliative care that is both comprehensive and accessible to all citizens of this nation. That is not the question or the matter before us, but I would like to emphasise the importance of that.

From the point of view of medical leaders, I would like to stress that we do not believe there should be any legislation or compulsion by law that a doctor be required to participate in voluntary assisted dying. This is a matter of choice. It is a matter of choice for the community and those within the community, but it also is a matter of choice for the doctors who may be involved and/or implicated one way or another, whether in an organisational setting or their professional setting. I emphasise that we would not support anything that would compel any medical practitioner to be put in that position. It is a matter of choice.

**CHAIR:** Just to clarify, are you talking about conscientious objection?

**Prof. Sandford:** I am talking about if there was a legal requirement that was going to compel a medical practitioner to participate in voluntary assisted dying.

**CHAIR:** Within the bill there is a requirement that, if you choose not to, you would be referred to a trained provider of VAD. Do you have any views on that?

**Prof. Sandford:** To refer to somebody else is a common practice amongst the profession. If one does not feel they are in a position to make a particular clinical judgement and/or participate in a particular procedure, then it is custom and practice to then refer to an alternate, but there must be that choice, and that is the key underlying principle in this setting.

**CHAIR:** Please continue on any other aspects of the bill.

**Prof. Sandford:** I will inform the committee that there has been consultation at a national level. We have a policy and advocacy committee within the Royal Australasian College of Medical Administrators, which covers Australia and New Zealand. The policy and advocacy committee has considered this very carefully. We have also put in a formal submission, so that group I represent and that submission is already before the committee.

**CHAIR:** Can I also ask whom you look after in your day-to-day role and in what context?

**Prof. Sandford:** Many will not know what a specialist medical administrator is. Many will think that I am not clinical. It is a clinical speciality. My day-to-day role is that I am the director of medical academic development, so I medically lead the creation of a regionally based medical program. It is very important and I am sure of great interest to committee members. It is a collaboration between two hospital and health services—Wide Bay as well as Central Queensland—and two universities—Central Queensland and the University of Queensland—to create locally trained doctors and end-to-end medical programs.

**CHAIR:** Can you please provide your views on the use of telehealth? If you have read the bill, there are some questions the Queensland Law Reform Commission raised around the provision of telehealth services so people have access and equity to VAD no matter where they live in Queensland should this bill be passed. Do you have any comments around the Commonwealth carriage law?

**Prof. Sandford:** The specific legislation or law that you are referring to is not before me. In terms of telehealth, in its broadest definition it is one of the most significant developments certainly within our rural, regional and remote communities. I recently worked in Mount Isa, north-western Queensland, in a remote community as well. I am very supportive, as are my college members, of anything that further sees the development of better access to services in whatever form within the realm of telehealth. Those services can be a very broad range of everything from teaching, training, direct advice and service delivery via vicarious and/or telehealth means. It is a very important mechanism by which those who are in isolated and remote sites are able to access appropriate, safe and professional advice and guidance.

**CHAIR:** I will put it in context. The former inquiry heard from people who live in remote communities. They did not want to leave their communities if they got on well. They wanted to be cared for there and not transferred off to an institution on the coast somewhere away from their community. Does the provision of telehealth currently include the delivery of end-of-life care, advice and palliative care?

**Prof. Sandford:** With respect to palliative care, telehealth does play an important part in treatment and/or access, so indeed any further expansion of any component of palliative care—any improvement of both the comprehensive nature and accessibility of palliative care—would be strongly supported. There is no contention in that respect. It currently exists already where appropriate. Telehealth advice, guidance, reassurance and all of those aspects, including support for patients who are in a palliative care situation, exist currently, and I would support any effort to further expand and strengthen that.

**Mr BERKMAN:** I appreciate your time very much, Professor Sandford. I am very interested in your take on conscientious objection, which you have already touched on. As I understand your evidence so far, there should be no compulsion for a medical practitioner to participate in VAD. As I understand it, the bill makes provision to avoid that. However, there are various views coming from submitters about the requirement to provide information to a patient who might make inquiries about VAD and even a suggestion from some that even responding to a request to even provide information is too much of an imposition on a conscientious objector. Can you go into any more detail for us and tease out those issues, whether it is in a religious institution or a completely secular hospital setting? Does this bill do well enough in terms of allowing for conscientious objection, in your view?

**Prof. Sandford:** I am not sure I really want to go down the path of what the definition of a conscientious objector is. That label may be restrictive in this regard, although I understand the intent of the question. The point is that practitioners have a choice as to whether they participate or not. How much they participate is also a choice. I do not know when that flicks into the realm of that definition of a conscientious objection. I do not think there is a defined line. The practitioner will be able to provide as much as they are comfortable and they choose to provide. If that means advice, that is a normal part of our medical practice. Where it then verges into advice which goes down a particular path is not distinct. I think there is an issue with the definitions there. It comes back to that which the practitioner is comfortable with doing in terms of their choice about how much they provide.

**Mr BERKMAN:** That is a very helpful answer, thank you. You mentioned in passing before that it is common practice in the profession to refer someone on to another practitioner. Does that apply equally in this circumstance, in your view?

**Prof. Sandford:** I believe it does. It is common practice that, when a practitioner is not able to deal with an issue, our usual practice is to refer that person on to someone. They may not know. They may say, 'You'll need to seek other advice.' But for the most part, medical practitioners will be able to direct people to alternate providers. Usually that is in a setting where they are referring to further expertise that they may not themselves have.

**Mr MOLHOEK:** It is good to see you again, Professor. We had the pleasure of catching up at the hospital probably two months ago now. In this public forum I would like to congratulate you for your passion to train and develop healthcare practitioners, specialists and carers in the regions. We know how difficult it is to get good people here and how so many who do end up going to university want to drift into the big cities. I am looking forward to cutting the ribbon with you maybe one day when we open a Central Queensland University school of medicine and we no longer have to send doctors and other specialists to Brisbane for training.

I want to ask a question about telehealth particularly. I take on board your comment that it is certainly a significant development. It is a huge step forward in that it does mean that people in isolated and remote areas can often get access to better medical advice, and often that would be life-saving or very significant in terms of the impact that has in perhaps preventing a loss of life. In terms

of providing that sort of service around end-of-life decisions, do you think telehealth is an adequate forum for people in isolated areas to have a conversation with a complete stranger, perhaps in a far-flung centre, about the sorts of choices and the process they would need to engage in if they wanted to take up the opportunity of voluntary assisted dying at end of life? Also, how does a practitioner on the other end assess where the person is really at in terms of their pain and their emotional state? Just broadly, how efficient can that be in that sort of setting?

**Prof. Sandford:** I think the question you ask is a complex one, and indeed that is a hallmark of the debate currently before us. We are living in a COVID era, one which has led to separations. Not only is there the geographic separation that we are currently experiencing but also the other separations. Telehealth and other vicarious mechanisms by which we come together and share are very much in our domain. I must say that at the end of the day I do feel as if I am a 'Zoombie'. There is not the same fidelity of interaction as there is when one gets together face to face with a gathering of people. Telehealth is an adjunct; it is not a replacement. It is a judgement or an assessment which varies, and it varies depending on the individuals. It depends on the culture and a variety of other things as to the adequacy or otherwise of that interaction.

I can say that, while it is not the same high-fidelity experience of meeting people, being face to face and having that opportunity for interchange discussion and all that goes with it, it is a step when other mechanisms are an adjunct. I am not sure that totally answers the question. I look forward to seeing the further development of the various technologically advanced mechanisms by which we can communicate. Once we get holographic figures and various other things then that fidelity will increase, but there is nothing like being with a practitioner face to face, with your family by your side. That is by far the most desirable, high-fidelity and high-quality interaction.

**Ms KING:** I, too, wanted to ask for your reflections on issues of conscientious objection. We have had a number of submitters who are seeking to incline the committee towards the view that not only should individual practitioners be entitled to stay out of the provision of voluntary assisted dying—which is a view I support personally—but also institutions like aged-care facilities or hospitals should be able to block people who are within those facilities from access to practitioners who might provide services and access to information about voluntary assisted dying that would help them make a decision about whether to go down that path or not. Can you give us your reflections on where you think that sits in relation to a practitioner's responsibility to provide person centred care?

**Prof. Sandford:** That our college is a great supporter of diversity in all aspects means diversity of opinion. That is where choice is critical in this discussion. In respect to access, anything that increases the access of any consumer community member to health services we also support. Overall, increasing accessibility and the comprehensive nature of health services is something our college and profession would support. In respect to the issue of conscientious objection, I do not wish to further prosecute that, other than to restress those points I have raised.

**Dr ROBINSON:** The *Second annual report on medical assistance in dying in Canada* has been presented. That report shows that nearly 7,600 Canadians' lives were ended in 2020 through legislation similar to this legislation. Of those, it is reported that 4,120 Canadians with cancer were euthanised with no discussion with an oncologist about that course of action. My question goes to safeguards and protections. In this legislation, no specialists are needed to be part of the process as a requirement—no palliative care specialist and no psychiatrist in terms of potential mental health issues. It only requires two non-specialist doctors—and we regard our doctors very highly—neither of whom are required to be known to the patient. Do you think that is safe?

**Prof. Sandford:** I do not have a specific answer or judgement that I can express on behalf of those I am representing, so I cannot specifically answer that question. What I can say that is relevant to that is that, as a specialist medical administrator and medical leader, we have a requirement and responsibility to have appropriate clinical governance arrangements in place within all of those facilities within which we work and have that important task. That includes having safeguards for the assurance of appropriate clinical governance. I am confident that our system would put in place those appropriate mechanisms to ensure that safety via clinical governance arrangements.

**Dr ROBINSON:** If the bill could be amended to ensure that there is some specialist who is part of the process of treatment, would that strengthen the bill in terms of safeguards, in your opinion?

**Prof. Sandford:** I am unsure what 'some specialists' are.

**Dr ROBINSON:** Palliative care—a mental health psychiatrist that would judge whether somebody has capacity. I realise that general practitioners can do that to a degree, so it is not undervaluing GPs. We have specialists because they provide more knowledgeable and in-depth specialisation in areas. Would it strengthen the bill, if it was to be amended?

**CHAIR:** I understand where the member is coming from, but it is a rewording of the previous question which I think has been answered.

**Dr ROBINSON:** No, it is just digging a bit further, Chair.

**CHAIR:** I will allow it. I will allow a bit of latitude.

**Prof. Sandford:** I am happy to add further granularity perhaps. Prior to joining you, I chaired the credentialing committee of the Central Queensland Hospital and Health Service. We assess people's qualifications, experience and demonstrated skills in the care they are providing to patients across Central Queensland. That is replicated across this nation and it is a part of our clinical governance framework.

It is about having the right people. It is workforce planning—the right people with the right skills in the right place at the right time. Specialist expertise can be in a variety of different ways and can be from a variety of different people, not all of them necessarily in one specialty field, for instance. Indeed, in rural, regional and remote areas we have rural generalists that have a variety of skills, which are themselves encompassing some of those that would fit within specialty groups. It is about assembling the correctly informed and experienced personnel to participate in any activity. That falls into the realm of the credentialing, the appropriate granting of scope of practice.

**Mr ANDREW:** Paula Ryan earlier made a statement about palliative care not being adequate, thereby reducing choice for a person who would probably look down the path of the VAD Bill. Do we have the structure set up in Central Queensland now for palliative care to be maintained and for this to be a choice?

**Prof. Sandford:** I do not think I can make a determination of the adequacy, because that is always relative; however, I can say—I think I stated it earlier—that the increase of access to and the comprehensive nature of palliative care across our nation is an objective shared by many across this nation, including my college as medical leaders. The adequacy is not necessarily something I would comment on. I strongly support the expansion of any service the community needs.

**CHAIR:** Thank you very much, Professor, for your contribution here today. It has certainly helped inform the committee in its deliberations over the bill before us. Thank you for your work in the community, too.

**O'ROURKE, Mr Barry, Member for Rockhampton, Parliament of Queensland**

**CHAIR:** I recognise the member for Rockhampton, good friend Barry O'Rourke. We were in a cab and the cabbie certainly knew him as a hardworking local member. Barry was also on the previous health committee that travelled extensively throughout Queensland and heard the views of Queenslanders on this issue. Barry, thanks very much for coming here today. Would you like to make an opening statement?

**Mr O'Rourke:** Thank you for the opportunity to make an opening statement. As you said, I was part of the 56th Parliament, where we travelled the state and met with approximately 500 witnesses and received over 5,000 submissions. We heard polarising views regarding voluntary assisted dying and there was an emphasis on the importance of choice.

The information that we collected then went to the Queensland Law Reform Commission to ensure we had a wide range of safeguards and strict eligibility criteria regarding assisted dying laws, allowing eligible people who are dying to choose the time and the circumstances of their death. The person's prognosis is that they are expected to die within 12 months and the person considers that the pain is intolerable. Another key safeguard of the bill is that the person must complete a staged request and assessment process and make three separate requests to access voluntary assisted dying.

The staged request and assessment process, together with the wait periods, ensures that the person's decision is to access voluntary assisted dying is enduring and not a fleeting decision made in a moment of pain or suffering. A medical practitioner or a nurse practitioner may initiate a discussion about voluntary assisted dying if, and only if, at the same time the practitioner also informs the person about the palliative care and treatment options available and the likely outcome of that care and/or treatment.

The Queensland Law Reform Commission considered that there was uncertainty and significant concerns around whether providing information and advice about voluntary assisted dying via a carriage service would contravene the Commonwealth Criminal Code. The Commonwealth Criminal Code makes it an offence to use a carriage service such as a telephone, videoconferencing, email and other electronic communication to publish or distribute materials that counsels or incites committing or attempting to commit suicide.

Given Queensland's geography—we know how large Queensland is; it is a massive state—it is difficult for any voluntary assisted dying scheme to ensure equity of access for people in rural and regional areas. While the Commonwealth Criminal Code provisions remain in place, because the Commonwealth law takes precedence under section 109 of the Constitution, the only way to definitely resolve this issue is for the Commonwealth to amend the Commonwealth Criminal Code to expressly exclude participation in any state government voluntary assisted dying schemes. I have worked the last 30-odd years across regional Queensland, and it is so important that people are able to access services. If that is telehealth services, that is what needs to happen.

**CHAIR:** Thank you very much, Barry. It is good to see you here. As a local member, no doubt you have consulted broadly in your own electorate. What is the feedback from your own community on this issue?

**Mr O'Rourke:** I actually did a survey on Facebook. There were nearly 700 respondents to that survey and 91 per cent of respondents were supportive of palliative care, which was great, which is very much reflective of this community, and I am supportive of that.

**Ms PEASE:** Is that palliative care or voluntary assisted dying?

**Mr O'Rourke:** Sorry, voluntary assisted dying.

**Ms PEASE:** Thank you for coming in. I know what a hardworking local member you are and how dedicated you are to your community and listen to the community. I would ask you to reflect on our time during the inquiry when we travelled around all of Queensland and heard from people, both professionals and community members, about their experiences. Can you give a brief reflection of what that was like out in the community for you?

**Mr O'Rourke:** I think one of the biggest things that I took away from those hearings was talking to a young fellow whose grandfather was terminally ill who actually committed suicide in the shed down in the backyard and that grandson finding his grandfather. When you look at some of the statistics, every four days someone with a terminal illness commits suicide in Queensland. We have to address these issues. There is palliative care, and we heard that it does not work for everyone. There are some people who are still in excruciating pain. Each and every one of us probably knows someone who has gone through a terrible ending where, if they had the choice, they may have headed in a different direction.

**Ms PEASE:** Thank you, Barry. I think you would agree that in most of the places—and how many places did we visit?

**CHAIR:** Forty-something places.

**Ms PEASE:** Forty-something places across Queensland, so we got to hear from people all across Queensland, and Barry was on the committee that undertook those hearings as well. That was a common story that we heard. There are over seven people a month who are taking their own life at the end of their life to ease intolerable pain. We heard yesterday from a woman, Dr McNamee, whom I mentioned earlier, who spoke about the fact that we heard on those journeys that there were doctors who are currently undertaking palliative sedation so people can end their life and pass off slowly to death, which is a form of unregulated voluntary assisted dying. Would you remember those conversations, Barry?

**Mr O'Rourke:** I heard those conversations from one end of the state to the other, whether it was an increase in morphine or whatever it was—some of the terminally ill begging beforehand, 'Don't leave me to die in pain,' and talking to their kids about that beforehand. We should be respecting people's rights and choices down the track.

**Ms PEASE:** Thanks, Barry. One of the other things that I remember hearing from a lot of people is that, because there was not an option, occasionally the doctors were not giving good pain relief or assistance so that they were left in terrible pain and starving and it was a terrible way to die.

**Mr O'Rourke:** Yes. I have seen that personally as well, where people just fade away in the end and if they had a choice they would have died with dignity. They had no control over their bowels or anything like that and it is really, really sad to see.

**Ms PEASE:** Before I go on, I would like to acknowledge the moderation and the degree of sensitivity and good manners that are normally on display in public hearings if we have differing views.

**Ms KING:** Barry, I wonder if you could reflect for me, having been to those 40 hearings right across Queensland—I know as a local member myself that people write to me quite often on this issue of voluntary assisted dying and they talk about their concerns about end of life. They talk about their fear of pain that will not be able to be relieved but they also talk about their experience of their relatives' fear and distress around loss of dignity, loss of ability to care for oneself. Can you tell us what you heard in those hearings on those topics?

**Mr O'Rourke:** There is always that concern about end of life and loss of dignity, particularly where they have had loved ones who had the same illness before them—parents or grandparents have died earlier than them—and just wanting to be able to have a choice. No person wants to die. No-one wants to die. If you are terminally ill, it is not your choice. I have watched quite a few people and I even look at people that I have known really well who just wanted to be able to exit when they were ready, when they had family there or whatever it was so they could actually plan around that. Just wanting to have a choice—that is it. We are not saying you have to do this, but if a person is terminally ill and in pain and they want to exit, we should be trying to help them. That survey I did very much reflected that: 91 per cent of the respondents here locally were in support of voluntary assisted dying.

**Ms KING:** Is it your view that that is the case whether you are a regional member like yourself or in an inner-city area?

**Mr O'Rourke:** I think regional Queensland seems to be a little bit higher than the south-east corner when you look at those sorts of figures. I would think we would see in excess of 80 per cent who are supportive of voluntary assisted dying and having a choice. I keep going back to choice.

**CHAIR:** Barry, you talked about your former career and how the farther you are away from South-East Queensland the harder it is to receive certain services. In terms of the issue of telehealth that you raised, the Queensland Law Reform Commission recommends that the Queensland government, in consultation with other state governments in which voluntary assisted dying legislation has been enacted, raise for the consideration of senior members of the Commonwealth government, including the ministers responsible for the justice and health portfolios, the urgent need to amend the relevant Commonwealth laws to clarify that voluntary assisted dying, which is authorised and lawful under state or territory laws, does not constitute suicide for the purposes of certain sections of the Criminal Code. That is certainly something that the committee considers going forward. We heard it in Townsville. You heard it yourself on that former committee where people did not want to leave their communities and to have access to and equity of care. I just thought I would clarify that rather than having people try and read through the 888 pages to find it. It is there.

**Dr ROBINSON:** Chair, I do have a question. Perhaps it is one that you may even handle, or Barry. For the sake of the room, there has been a response from the federal government on the issue of telehealth. My understanding is that, under standard definitions, there is a degree to which in law Rockhampton

VAD as a form of—one way of describing it—assisted suicide may still fall under commonly understood definitions and interpretation by some magistrates. At this point the federal government's position, as I understand it from Minister Greg Hunt himself, is that they have concerns about wholesale changes of commonly understood definitions that in courts may not stand up.

**Mr O'Rourke:** I would hope that it does get addressed, because people in regional, rural and remote Queensland do want to get access to VAD. If the federal legislation is out of step with that, we do need to address it. It is so important not to be disadvantaging people because they do not live in the big cities.

**Dr ROBINSON:** What I am saying is that it is not a function of regionality. I do appreciate what we are talking about in terms of relieving the suffering of those who are at end of life, that it is more difficult at times to provide a whole range of services in regional and rural areas and we need to overcome that across all kinds of medical services. The point I am giving feedback to the committee on is: Greg Hunt's comment is that it is problematic around a telehealth service and the interpretation by courts, by magistrates, to say that they must not see voluntary assisted dying as assisted suicide, again, when commonly understood definitions and legal definitions may include it as a form of assisted suicide. It is not about the regionality issue—that is across the board; it is about a legal and definition issue. Though many may want to redefine it, you cannot redefine universally understood terms in law.

**Ms PEASE:** Except by legislation, of course, member.

**CHAIR:** We do not want to get into a debate. We will save that one for the House, but I will direct the member to 1.5 of the Queensland Law Reform Commission's submission and recommendations in a chapter titled 'A dying person who chooses this option does not die by suicide'. All the legal argument is in there.

**Dr ROBINSON:** It is a legal opinion. That is what it is.

**CHAIR:** We will leave that for the House. We have certainly heard the views from the local member. Thank you, Barry, for your contribution.

**HERBERT, Ms Catherine, Private capacity**

**CHAIR:** Generally we allow three-minute statements. We are a little ahead of time. We may or may not ask questions. We will keep it as informal as possible.

**Ms Herbert:** Thank you for giving me this chance to speak. I am a member of the community. I belong to no organisation, no church group—nothing. I have very strong views on this subject and—surprise, surprise—as Barry O’Rourke said, like probably 80 per cent of the population of Australia, I support voluntary assisted dying. I support the legislation. I have been listening very carefully to some of those on the committee who do not share my views. Sure, everyone is entitled to their view.

My comment, which no-one has referred to, except perhaps obliquely, is that, if the legislation comes in, no matter what choice people want to make, either having palliative care or whatever treatment, the knowledge that you have an opportunity to make the choice to ask for this would provide such a comfort. It certainly will to me and it would have done to my mother when she died in 2017.

My mother was desperate. She did want to die. She had no pain. She was 97. She had to breathe oxygen all the time. Her skin was so sensitive that anyone who touched it bruised it. She could not walk. She had an ileostomy so she had a bag for her bladder. She wanted to go. She told anyone who would listen that she wanted to go but she was terrified of the process. If she could have had a pill, or whatever was the way to do it, she would have said, ‘Good, I have a choice. Now I can decide when.’

I think it is time for all these learned people to stop treating individuals like idiots as we get older and like children who really do not know our minds, that we just need explained to us just a little bit more what it really means. We have all thought about it. Nobody who gets older does not think about death because we are all going to die and nobody wants to die in pain, as you say, and all the rest.

Palliative care is certainly in the mix. It does not exist here; we know that. I am all in favour of palliative care, but if I do not want palliative care stop trying to tell me I do. That is my message. I support the bill. I think there is more good sense in the community than some wish to acknowledge. We do think about it. When our time comes, we want to know that there is some means of doing this.

I have just one last point: when you were talking to Barry O’Rourke it was said that you have a three-stage process to save us all from making a wrong decision when you have already made it. Okay. My fear is that by the time you get through this three-stage process you might already be dead. We need a process that is timely as well. May I say that we have been waiting decades for this. The whole community of Australia has been waiting decades. One survey after the other has shown that so let us get on with it, please.

**CHAIR:** Well said. Thank you very much, Catherine, for your contribution.

**CAMPBELL, Mr John, Private capacity**

**CHAIR:** Welcome, John.

**Mr Campbell:** Thank you. I will read out my statement for efficiency and then I have some points to refer to about what has been raised through the discussions. This euthanasia bill being proposed is another step in dismantling the foundational principles governing our democracy that has been serving us so well. Civilisations in the past have operated without any civil government. Everyone did what was right in their own eyes. For civilisation to progress we need civil government. The state exists for the wellbeing of its citizens and neighbours. Wellbeing is not death. Death is the absence of life. It is also the wages for sin. Death, therefore, cannot be promoted by an institution that is designed to advance and protect the wellbeing of its citizens. We have legalised murder at the beginning of life. Now we are promoting the same at the end of life. This must be stopped.

Suicide is an act of selfishness. We as a society need to show more care and responsibility. Responsibility was raised by the professor as well. We need to reach out to others for help. I need help and I need to help others. Pain and suffering are guaranteed in life. Suicide does not eliminate pain and suffering, only life without hope. When someone's heart is beating, they are valued and precious. What was the reason for the occupational health and safety act to come about? We have a duty of care. Euthanasia opposes this principle. Every human being has a moral code of conduct. The state cannot determine morality, only promote the highest on offer.

How many of you in the public trust politicians? How many of you have had bad experiences with government departments? By referring to that, we are all flawed here. I am not pointing the finger at anybody. The law is only as good as those who operate it. I hope they care. Queensland voters have been negligent in casting their votes by not ensuring the candidates they voted for were of sound moral integrity. Here we are today, discussing how to legally take another person's life from them.

The foundational philosophy behind euthanasia is the theory of evolution. This theory has not one piece of evidence supporting it, yet we have the law of survival which opposes euthanasia/murder. By continuing to promote death, our democracy is slowly being transformed into something like what China has: more pain and suffering. For the sake of the vulnerable, let us throw this bill out. L'haim—to life!

I will go quickly through some points. Palliative care: there is always going to be pressure to reduce funding by promoting euthanasia. When has there ever been sufficient funding for health care? Choice: to do what is right or to do what is wrong. Making wrong decisions. Intolerable pain: how do we define that? Rights and responsibility: Viktor Frankl, the Austrian psychologist, neurologist and philosopher, had a lot to say on rights and responsibility. This is what is being promoted at the moment: it is all about rights; I hear very little about responsibility. What this bill is doing is saying that those who want to commit suicide or VAD are asking for someone else to take that responsibility away from them.

No-one wants to die; that is true. What happens after death? Someone who wanted to die: I refer to the Apostle Paul, who said, 'I prefer to die but for your sakes it is better that I live.' That is a great motivation. I prefer to die myself—because we are all terminal; we are all going to die—but for your sakes, for my children's sakes, for the community's sake, I choose to live, to leave something, to reach out, to give, to love. This is not the first time someone wants to die because you know what is beyond life here on earth: there is something good to look forward to.

One more thing: when it comes to health care, I looked after deaf and blind people for a period. It was the hardest job I have ever done. Those people would be onboard for someone making a decision for the ending of their life because of their severe handicaps. When we legalise murder, the taking of another person's life, the door is wide open just to keep pushing the boundaries.

**CHAIR:** Currently on what is before us, you have to be diagnosed with a terminal illness. You asked a question. My observation would be to please read *Hansard* of the Townsville hearing. You asked how you define 'intolerable pain'. Dr Will Cairns gave some pretty graphic evidence yesterday of that. Perhaps avail yourself of that, sir. You have made your statement. I understand that there are respectful and divergent views on this. Let us keep it at that so everyone can have their say. Thank you very much.

**McINALLY, Mr Maurice, Private capacity**

**Mr McNally:** Thank you all for coming. I am very insignificant compared to you. You are all very powerful people in the community and it is very necessary to have you here. I did go to the first meeting. It was very well attended. I cannot see how many people are behind me; I have not looked. This is a very serious matter. Somehow I do not think we always understand the seriousness of it. We all were born into a family and we all were born with a particular bias in life. That bias influences us, if we are true to it, for the rest of our lives. The word 'lives' is a very important thing. The word 'lives' you can also pronounce as 'lives'. That is another way of pronouncing that word.

I have had cancer myself. I have had two heart attacks. They call them widow makers. I should be dead. After I had the heart attack I got very depressed and very sad. I felt very crook, but I had a very good doctor. He himself has passed away. He said, 'Maurice, when part of your body dies there is a grieving process that goes on. You don't know it but that is what happens. You feel like the rest of you wants to die.' If someone had the opportunity to press the button, I could have died but I am still alive. That happened on 10 January 1997. Medical science treated me for a wind attack but, by the grace of God, I am here today. I am happy to see your faces.

However, to live is a very important thing. To see you all here today, you are alive. You are living. You are doing a job. We do have different points of view and it is good to have a different point of view. However, God has a point of view. God created you; he created me. Whether you believe it or not, it is a fact. I did not believe it years ago but I came to believe it more so after I had my heart attack. It really changed my life. I have to say to you that I met so many wonderful people in the hospital, whether I was in Brisbane or in Rockhampton.

I went to Brisbane. They put me on a plane. I should have had a carer but I did not have a carer because I did not know you could have a carer. When I got there, the lovely ladies in the plane put me on one of those little machines and took me down the front. They looked after me. They cared for my life. I did not know them but that was their values. That was what they had in them. They cared more about me living than dying. They found out that I was a heart patient. I went to the Wesley Hospital. I was there for a month. I had several things for treatment and finally they did a treatment on me and I am still going as a result of that treatment. I still do get heart pain.

It is a very interesting thing, because you do not know when you are going to die. However, I can say I have had a lot of people to encourage me. Today you people are encouraging me too, because this is an opportunity to say that medical science does not have all the answers. But people at the hospice are trying to help and they are asking you to help them. I think that is a great thing. That is an opportunity to say we need more money to do something. Money does not grow on trees. I know that.

We have to consider some of the programs that we do have in government. If the bill is going to serve what you want it to serve—and I believe you are all earnest in respect of it—then it has to be funded. People need help. I do not know who here has had pain. I had terrible pain with my heart attack. A lot of people can die without pain. It felt like there was a D157 pushing me into the bed, full throttle. That was the pain that I had, but I got through it. In the morning, I saw the light of day. They said, 'Don't get out of bed. Stay there,' but I wanted to get out of bed. That is a willingness to live—to get up and go and to get up and do things.

I was a farmer's son. I saw the light of day. I saw the sun shining. I saw the moon and stars at night. I have a lot of things to be thankful for and I think you have, too. Queensland is one of the best states in Australia. We call it the Sunshine State. When we see the sun in the morning, we can say, 'I'm alive' and it is something that we want to live for. Let's live for today. Let's live for tomorrow. Let's promote life. Let's see the good things in the bill. Let's reinforce them. Let's strengthen them. I do not think government should fund everything. The community can still help. I believe that the hospice is doing a great job. I did not know about it until today. I have learned something. I really think living is so important. I cannot say it enough. I am glad to be alive and I am glad to see your happy, smiling face again, Aaron.

**CHAIR:** Thank you very much for your contribution.

**CHASE, Reverend Doctor Andrew, Private capacity**

**GALL, Reverend Andrew, Private capacity**

**CHAIR:** Thank you, gentlemen. Would you like to make an opening statement on the bill?

**Rev. Dr Chase:** It is purely coincidental that we are both Andrews. We have not met before today. I am Catholic; he is Anglican. Thanks very much for the opportunity to speak today. I will try and keep it brief and to the point about the legislation.

My basic concern about this bill is that it begins to shift the focus of the healthcare profession from being just that—a focus on caring for the health of individuals—towards a utilitarian view of human life. That is certainly not the stated aim—and I am sure that is not the intended aim of the people who support this bill—but I think, by presenting the deliberate ending of one's own life as a valid approach to dealing with illness and suffering, this bill will contribute to a social shift in how we understand and value the ultimate dignity of all human life.

Among various problems that I would have with this bill, let me highlight two, in the interests of time. First, the lack of a requirement for proper evaluation from a mental health professional could, I believe, lead some people to accessing VAD because of depression and mental anguish and perhaps even a sense that they are a burden on their families or society because of their illness or disability. I think that is especially the case when, as we note in the bill, a practitioner can raise the possibility of VAD with the patient involved as long as they do so alongside telling them about palliative care options. Inadvertently, what can be communicated there is that assisted dying is kind of an equivalent to palliative care. Even though that may not be the intention, that may be what is heard.

I think the inadequate investment in proper palliative care, especially outside the south-east corner, means that many Queenslanders are not able to access palliative care, yet they will be presented with euthanasia as essentially an equivalent medical alternative when in fact it is a fundamentally different act from the receipt of proper palliative care, which offers both physical relief from pain and respect for basic human dignity. That is the first area of concern I have.

The second is around the ability to conscientiously object to cooperating in an action that one believes to be fundamentally unethical. I note that the bill certainly allows the medical practitioner to choose not to actively engage in the VAD process, but it does require medical professionals and healthcare providers to give a patient information about another medical professional that they know is willing to provide the VAD service. As we have heard today, doctors routinely refer to other professionals for all sorts of reasons but, essentially, those routine referrals are when that particular doctor or professional is unable to provide that particular service. Either they do not have the time or, more likely, they do not have the particular skills involved, so they refer to someone who can do that. When one's basic commitment to health care rests on the principle that first of all we try to heal and if we cannot do that we try to provide care for the person, the referral for euthanasia is not something that I feel one can do in good conscience. To do so would be to formally cooperate in an act that one believes to be essentially unethical. Numerous medical professionals and healthcare providers would be required by this bill to participate in a process to which their basic mission is fundamentally opposed.

I have deep concerns about this bill and I would simply ask that all members who are going to vote on this legislation consider very seriously the fundamental shift in our understanding of the dignity of the human person that I think it will bring about.

**Rev. Gall:** I am an Anglican priest in Rockhampton. I am an Anglican chaplain at the Rockhampton Base Hospital. You were far more articulate, Father Andrew, than what I am about to say, but essentially we are on the same page. Personally, being a Christian and an Anglican priest, I am opposed to this dangerous bill.

As I mentioned, I am the Anglican hospital chaplain at the Rockhampton Base Hospital. Over my years of being a Christian minister, I have prayed with and ministered to possibly hundreds of people in hospital and gone on to take a number of funerals of those folk. I can testify to the fact that obviously euthanasia and this sort of voluntary assisted dying is being discussed a lot at the moment but over the last few years in particular. I can give the committee a couple of examples where family and individuals themselves have talked with me in terms of, 'If only this were legal, I would avail myself of it.' On one occasion, the man almost miraculously recovered and is now a member of our community. On another occasion, a man was ostracised from his family and daughter and wanted—if this were available—to avail himself of it, yet through various circumstances his daughter came in, he was reconciled to members of his family before he then died and I took his funeral. They are real-life examples of things that may not have happened if voluntary assisted dying had been law in Queensland. They are just a couple of real-life examples that I draw your attention to.

Our current hospital care at the end of life is very good, but we do need funding to be directed towards palliative care. Our nurses and doctors do a great job, but I agree with the lady from the hospice who talked earlier. She used the example of a lady dying in the emergency department. I have experienced similar things. The level of funding is not there at the Rockhampton Base Hospital. People are being transferred; beds are not available. There are terrible stories, and I will not go into details. Our nurses and doctors are doing all they can, but we do need more funding for palliative care in particular, not laws that will help people kill themselves. Christians believe that every human being is made in God's image and all human life is sacred from conception to natural death; therefore, we should not encourage the voluntary assisted dying bill, particularly in its current state. Human life is sacred; all life belongs to God.

In particular, Anglican Christians are opposed to doctors and Christian health institutions with a conscientious objection to euthanasia or assisted suicide being forced to refer patients and health institutions being forced to let the assisted suicide or euthanasia take place on their premises. They are particular examples of problems I have with the bill. Anglicare and many other large Christian health service providers are opposed to this legislation. What are some of the possible implications? It may result in certain Christian aged-care facilities being closed. That may further increase the cost to taxpayers to open more facilities or deny the access of certain citizens to aged care. What Queenslanders need, especially in rural and remote areas, is substantial increases to palliative care funding, not laws to enact voluntary assisted dying.

**CHAIR:** Thank you very much, Father Andrew. I will make a couple of observations. I will perhaps go straight to the institutional objection that you raised. This has been raised previously. Bishop Joseph talked about this yesterday. Does the institution's objection override the person who has resided there? It is their home. It is where their clothes are. It is where they have been for a number of years. Does that institutional objection—this might be a moral and ethical question—override the person's right to choose? It is a really difficult one. Think that one through if you want. I put that to the bishop yesterday, and I would be interested in your response. Is there a hierarchy?

**Rev. Gall:** Obviously we are not at the stage where this is law yet, but if it is it could be up-front and stated that, say, 'This is an Anglican aged-care facility and the doctors or the nurses in this facility do not provide this option'. It could be up-front so that people know going in. If someone resides there for two, five or 10 years, they know that it is not an option in that institution. That would be my possible way of tackling it, but I do not know. That is just off the top of my head.

**CHAIR:** Andrew, you talked about a mental health specialist. In Townsville yesterday Dr Heather McNamee said that most of the GPs who had treated and had a working relationship with their patients over many years would know whether they were suffering some mental anguish and did not agree with that same question being put. She said it is the GP who has the close working relationship who should be able to assess a person's capacity and mental capacity. Do you have any views on that?

**Rev. Dr Chase:** I am sure that is absolutely correct for the large majority of people, but does the legislation require that it is the person's GP who has known them for some time who is the practitioner who actions the VAD process?

**Dr ROBINSON:** The doctors said no, that they do not have to have any patient relationship at all. They may not know them, may have never met them and may never have had a prior conversation with them.

**Rev. Dr Chase:** I would imagine that if this legislation was passed and someone wanted to avail themselves of it, probably in many cases—possibly most cases—it would be that person's GP who possibly does know them. From what you are saying, Dr Robinson, there could well be cases where that is not the case. Even if it is that person's GP—I am not a medical person myself, but I could imagine that having a person who is a specialist in mental health issues or psychological issues would be better placed than perhaps a GP to judge whether this person is feeling pressure from society or from their own depression or whatever they might be suffering from. That would be my concern around that.

**Ms KING:** I do want to thank you both and acknowledge the work that I am sure you both do with dying people in a range of settings. I am sure that work, particularly for you in your role, Reverend, must be exacting. Clearly, you provide a lot of comfort.

Going to the issue of institutional conscientious objection, I note that very substantial polling and careful opinion gathering has demonstrated that, of active religious participants in Australia—there was a survey of over 200,000 respondents—75 per cent agreed with voluntary assisted dying. That included 71 per cent of Catholics, 68 per cent of Protestants and 77 per cent of Uniting Church Rockhampton

respondents. I put it to you that there are clearly a range of views within your own faith community and that perhaps the views of the institutional heads do not in fact accord with the views of the faith community. I would love your response to that, please.

**Dr ROBINSON:** Chair, could the member for Pumicestone cite that research, please? That sounds like very abnormal research to me.

**Ms KING:** Those results have been replicated in a range of research—

**Dr ROBINSON:** Can you cite one? Can you cite who it is?

**Ms KING:** Yes, I am getting there. That was the ABC's Vote Compass, but it has also been replicated by the polling that was done by the Clem Jones Foundation in early 2020.

**Dr ROBINSON:** That is great research.

**Rev. Gall:** I would simply just say that I conduct Bible studies, for example, weekly in my parish. Just because someone does not have a knowledge of the Bible or knowledge of the faith or knowledge of what we are teaching as Anglicans or Christians, they are obviously welcome to come and learn what we preach and what we believe. We have certain statements, 39 articles of religion, and Catholics have their catechism. I am sure that not everyone in our individual parishes would be able to rattle that off. As I said, what I said about death, life, dying, euthanasia and all life being sacred to God was quoted from an Anglican catechism.

Because we have not taught our people faithfully over the last few generations or they cannot articulate the faith and know exactly what we believe as Christians, I believe it is part of my role to teach the faith and to, God willing, explain to them the difference between Christian faith and the secular pagan world that we live in today which promotes this sort of death culture. Just because someone ticks a box, that might be their own view. If they come to the church and they want to know what the church believes, then as an Anglican I would tell them, 'This is what our church believes. This is what we believe the Bible says. This is how we interpret it.' That is why I went to theological college for a number of years so I can hopefully do that sort of thing adequately.

**Ms KING:** Have you experienced a range of views on this within your own faith community?

**Rev. Gall:** Yes, certainly.

**Rev. Dr Chase:** Can I just add to that and basically agree with a lot of what Andrew said. Within our community certainly there is a range of views. There would be some people who identify as Catholics who do not subscribe to all of the official teachings of the Catholic Church. One simple example might be that Pope Francis has spoken quite a lot in recent times about the importance of taking care of our natural environment. There would be some people in our congregations who disagree with him on that; nevertheless, that remains the teaching of our church.

On the position of assisted dying, or euthanasia, there is a very, very clear position within the Catholic faith. While there may be some people who identify as Catholics who say, 'I do not agree with that,' that does not make it any less part of the official teaching of the Catholic faith and therefore something that is very clearly understood at the outset as being part of the values held by a Catholic institution such as a hospital or an aged-care setting.

**Mr MOLHOEK:** I promised myself I was not going to go here during the hearings, but we have two eminent theologians present so I thought it might be an opportunity to ask this question. I have raised this with some of the other Christian organisations that have made submissions, and they promised me they are going to get back to me with some material later this week. I have struggled to find scriptures that directly talk about this issue. I can certainly find plenty of scriptures that talk about the sanctity of life and how precious life is. That is not my question. My concern is that, on one hand, we have become so good at playing God in respect of keeping people alive, often beyond what is reasonable. My question is: is it such a dilemma to allow someone choice when, on the other hand, we are actually providing so much choice at enormous expense with no regard for others in the world who are perhaps suffering far beyond? We have the incredible luxury in our nation of being able to provide these incredible levels of care, but at what point is that no longer reasonable or becoming excessive? That is the struggle I am having. Here we live in rich old Australia, the Lucky Country. We can have more psychologists, more doctors, more specialists, more experts and we can hook people up to machines, but theologically where does that sit? Where is the balance in sustaining and ending life?

**Rev. Gall:** From my point of view, if you are artificially sustaining life and you turn off the switch, then obviously the person will die. If they die, then I view that as God's will. I think that is entirely different than actively injecting someone with a drug and stopping their heart. That is obviously where we get the difference between one act and another. I think that is where I draw the line.

**Rev. Dr Chase:** I would agree with that. I would also just say that it has always been a pretty clear position within Catholic moral theology that we are not required to use extraordinary means to keep someone alive. Sometimes people get the wrong impression of the Catholic faith—although I know that would never happen in a secular society! They get this idea that we have to keep someone alive at all costs, otherwise it is a great sin. Nothing could be further from the truth. The Catholic moral position—and a lot of mainstream Christian positions—has always been that there is no requirement to use extraordinary means to keep someone alive. What is required is simply the basics of care for the dignity of the person, and then there becomes a much clearer distinction between looking after someone, providing what healing capacity we can, and then allowing nature to take its course, while on the other hand acting explicitly and positively to end somebody's life.

**Dr ROBINSON:** Can I commend both of you as people of faith and leaders for being available for the committee. As a pastor myself, sometimes I find that these events can turn into a little bit of a 'Christians before the lions' situation and you having to justify why you have a belief. Thank you for coming and being open about your values. In a post-modern world you have every right to them, the same as any other Australian, so thank you.

I just wanted to clarify something. As a pastor and having met probably many tens of thousands of Christian people in my lifetime as a leader, and also having had a background as an atheist—I have seen both sides of the fence, if you like—my sense of the evangelical and Pentecostal church community, which is growing large, is that there would be a very high majority of people who would not support this legislation. The question has gone to institutions versus the individuals. Yes, there are variables. In my faith tradition and related evangelical churches there would be as high as 90 per cent opposition, in my professional view. I would like to clarify your position on this point. Would you say that a majority, in terms of Catholic and Anglican people, from your experience would be either—if you had to come down to it—for or against the legislation? What is the broad overview in your faith tradition?

**Rev. Dr Chase:** It would be very clearly against the legislation. The figure that Ali raised before: I am not sure of the methodology used there. Possibly ABC Vote Compass is better methodologically than the Facebook stats Mr O'Rourke mentioned before. That kind of polling would be very unreliable. Even so, I think that could well be a picture of a percentage of people who tick the box 'Catholic' or 'Christian' on the Census, whereas if you look at those who would call themselves regularly actively involved in the church I think the figure would be quite different. If you looked at those who were in a church most Sundays, I think there would be a much higher number opposed to the legislation.

**Dr ROBINSON:** Do you have a view in terms of the Anglican Church?

**Rev. Gall:** It is basically similar. Those in the church tend to be more conservative, so they would be more traditional and opposed to voluntary assisted dying. The Anglican Church is also a very broad church, so you get groups that are more traditional, Bible believing, and you get other places that are a lot broader.

**CHAIR:** Thank you very much. We are out of time for this session. I will explain what is going on in a moment. To both Reverends Andrew, thank you for your contributions here today.

We are halfway through the statements from the floor and we have another five to go. I would like to recognise the member for Keppel, Brittany Lauga MP, and call her to the table. We know how busy MPs are, so we might hear from her and then we will continue with statements from the floor. Welcome, and thank you very much for being here.

**LAUGA, Ms Brittany, Member for Keppel, Parliament of Queensland**

**Ms Lauga:** Hello, health committee. It is wonderful to have you in Rockhampton. Thank you for making the time to come up here. I recognise there are a number of people who want to make statements from the floor, so I will do my best to make this really brief.

Can I acknowledge all of the work this committee has done as part of this inquiry and also the last inquiry and your commitment as members of parliament to travel right across the state to hear from communities right across Queensland about this bill before the parliament. Can I acknowledge you, Mr Chair, for the work that you have done not only in this inquiry but also in the past, because I know that the health committee, aside from this inquiry, also has a large body of work that you are undertaking. Thank you for making the time to hear from people in our local community here in Rocky. If you were staying tonight I would have loved to join you for a steak and a beer this evening. Unfortunately, you will not get to experience our Rockhampton hospitality.

**CHAIR:** We will come back next Beef Week.

**Ms Lauga:** I said publicly very early on that I support this bill and that I will be using my conscience vote in the Queensland parliament to vote in support of this bill.

Carrying on from the former speakers, there was a comment made that ‘all life is God’s life’. I most certainly disagree with that in that my life is not God’s life; my life is my life. I agree that life is precious, and that is exactly why I believe that this bill has adequate safeguards. One of the really important parts of this bill that I was wanting to see was the safeguards that were included in it. I thank the Queensland Law Reform Commission for their work in consultation and looking at other jurisdictions and the ways in which we can include those safeguards in our legislation. I do not think that religion should be part of this at all. This is fundamentally about human beings, and I believe that freedom is only truly achieved when a human being has control over their own body. I welcome this bill.

I agree with the previous speakers that palliative care is incredibly important and an important part of this whole story when it comes to end of life. However, the previous speaker said that palliative care is really the only way in terms of end-of-life care. I believe we need both. I believe we need a strong, robust voluntary assisted dying framework and we also need a strong and robust palliative care framework.

I would also like to thank the chair, Jacqui and the committee secretariat for their work. I know it is a huge amount of work you do to arrange all of these committee inquiries, but we really do value the work that you do to come out to regional Queensland and hear everyone’s views.

We know that voluntary assisted dying and other end-of-life choices are extremely complex and deeply personal issues. From the outset, I want to make perfectly clear my stance on the legislation. I have said numerous times publicly that I am in favour of this bill. Introducing this bill is part of an election commitment from the Premier, Anastacia Palaszczuk. She said in May—

When the time comes, government MPs will vote according to their conscience. This must be beyond politics.

I concur with her sentiment and I am confident in my belief that our society is ready for and deserves this VAD legislation. That is why it is so important that we get this right and make sure that the public’s comments and concerns are addressed.

In coming to my decision to support the bill, I have listened to comments and correspondence from scores of constituents in my electorate of Keppel. Some of those reflect some confusion about how the bill will be applied. For example, Helen Magnussen from The Caves wrote to me and said—

There are so many problems with this bill. For one, how can a patient be given access to assisted suicide without being required to see a specialist in the area of their suffering? This is just one of the terrible failures in this bill. I urge you to reject it.

Another said—

A cancer patient does not need to see an oncologist before they are approved to kill themselves. What if their condition is improving?

John, in Norman Gardens, said—

What if there are other treatments? What if there are other support networks that could dramatically improve their life?

I believe that the bill has answers to all of these questions. I am sure that some of these questions have been raised in the consultation that you have had throughout the state already. I definitely understand and empathise with their opinions.

My role as a member of parliament is to assess often complex legislation such as this bill, come to my own decisions to support or otherwise and declare that opinion publicly. While there were several opponents to the bill, there were many others who wrote to me who support it, such as this email from Lorna in North Rockhampton—

I believe that voluntary assisted dying needs to become legal in Queensland and Australia for those who want the choice. My quality of life should be my choice here in Queensland, Australia. I thank you that you have publicly supported VAD and hope you will follow through and vote for this legislation.

Most recently I heard from Joss Hall, a retired nurse of 48 years who watched her father die from liver cancer in 1980. Her situation with her father was similar to other cases I have heard. It is one of the reasons I back this bill which, I believe, seeks to give people who are suffering and dying and who meet eligibility criteria the option of requesting medical assistance to end their lives.

Many people might be concerned at the checks and balances in the bill, but I believe it establishes safeguards to ensure that the process is accessed only by persons who are assessed to be eligible and to protect vulnerable persons from coercion and exploitation. These safeguards in the bill ensure only those at the end of life can make these choices and then only those capable of making that choice for themselves.

In 2019 I attended the parliamentary committee's inquiry hearing in Rockhampton where local people presented as witnesses, and I heard firsthand the incredibly painful stories of Central Queenslanders who had witnessed loved ones with a terminal illness die a horrible and painful death. I have also received hundreds of letters of support from members of the community in my electorate in support of this legislation.

This bill is about people, it is about dignity and it is about choice. Voluntary assisted dying must be voluntary, supported by a person's medical team. It is not suicide. Voluntary assisted dying is not a choice between life and death; it is a choice for those who are dying and wish to have more control over the time and circumstances of their death. This bill recognises that people's autonomy and dignity should be respected when making end-of-life choices.

In summary, I would like to reiterate my support for the bill, thank the Queensland Law Reform Commission for their work in drafting the bill and acknowledge the committee's inquiry process, which will ultimately make a recommendation. I look forward to the debate in the House.

**CHAIR:** I asked the member for Rockhampton what consultation he had done in his local community to arrive at a point where he could vote. A conscience vote should not only reflect your own belief but also talk on behalf of your electorate. Have you conducted any other group meetings, forums or general conversations through the electorate office to guide you to this view?

**Ms Lauga:** I have been willing to hear, as I am with all issues, from constituents who contact me about any issue, and I have not had anyone contact me who wants to meet with me who is against this legislation. I have only had letters of support. I have had a few letters from people who are against the legislation. By and large, of the people who have contacted me over the years, I would say it is probably 97 per cent in support and three per cent against—and that is not just within the framework of this bill, either; this inquiry dates back to 2019. I am confident that the constituents I represent know that if they want to talk to me about an issue they can. I would suggest that the lack of people wanting to voice their disagreement with this bill is evidence of the fact that there are not many people who want to lobby me to change my position.

**CHAIR:** There being no questions, we thank the member for Keppel.

**BELZ, Mr Peter, Private capacity**

**McDONALD, Mr Max, Private capacity**

**CHAIR:** Welcome to both of you. Peter, would you like to go first?

**Mr Belz:** I have a few problems with speaking because of my condition. My condition is such that I have been diagnosed with motor neurone disease. During the years, I have been sent down to Brisbane time after time after time. I then contracted bowel cancer. I have been fighting on those two fronts for quite some time. Now I am at a stage where I can no longer live at home because I need help, so I am in an aged-care home in Rockhampton.

One of the things I see is that people are scared of death. Yes, I believe in that intrinsically because you will fight for every toenail, whatever—you will grab hold of life in any event. The very thing that has brought me to speak here tonight is that I no longer fear death; I fear the living. I would just like to make a distinction first.

I can see that, in your mind, you can go to all sorts of imaginings of good and bad, to the extremes of both. I have been to both extremes of them both. On the bad side of the imaginings, it is truly horrific. Really, I walk past every morning the reality of the living, not imagination. I walk past rows of people who are the embodiment of supposed living, and it is horrific. Not only is it horrific from the point of view of physical pain but also it is much more exacerbated in the sense of mental pain, I would suggest. That is the main thing, yet I recognise you will fight tooth and nail to live, push uphill under water—they will struggle like crazy. As I say, this situation where I am now has changed my mind, so thank you very much for VAD.

**CHAIR:** Thank you, Peter. It is incredible that you have come before us today as you suffer during this awful disease—motor neurone disease. In our previous hearings we have met people, other sufferers of neurodegenerative diseases like motor neurone disease, who have expressed their support, or some told the committee they would find a way to end their life because they did not want to suffer at end of life.

**Mr Belz:** Exactly.

**CHAIR:** My sympathies to you, sir. I want to get clarification: you support this bill the way it sits before the committee at the moment?

**Mr Belz:** I would say yes, definitely.

**CHAIR:** Thank you, Peter. Thank you for sharing your very personal story with everyone. Our sympathies to you, sir.

**Mr Belz:** Thank you.

**Mr McDonald:** My name is Max McDonald. I am a retired anaesthetist, but I am here as a member of the general public. I understand that we are here discussing the bill as it stands and if there are any recommendations people can make. I am not a speaker; being an anaesthetist, I do not talk to my patients. The important aspect, from my point of view, is that you have a choice. It is voluntary assisted dying. I have not read the document because it is 113 pages and there is a lot of legal business in it, but I understand from today's hearing that you have to request three times. I am not sure what the period between those requests is.

**Ms KING:** A minimum of nine days unless there are special circumstances.

**Mr McDonald:** I was wondering about that; I would not want it to be months. Another point is that we have been concentrating on pain and suffering but, as you can see with Peter, there are a whole lot of other conditions of incapacity where people just cannot—say you have someone perhaps with quadriplegia, it is becoming intolerable or, as in Peter's case, they will die of suffocation. That is one of the things he is most frightened of, that he will not be able to breathe or swallow or ingest food. It is not just pain. Trying to keep someone comfortable is, to my mind, slow torture.

The other thing about today that was not clarified in my mind was that it is not compulsory for a medical practitioner to participate and the question was asked, well, is it compulsory for them to refer them to someone and to me that was not answered very precisely. I think that is probably left to the legal people.

**CHAIR:** There is provision within the bill that a GP or medical practitioner who refuses or is a conscientious objector must refer the person to a provider who does. Just to clarify, that is within the draft bill before us.

**Mr McDonald:** The ministers who were talking today were giving the impression that associations—the churches—could mandate that they were not allowed to refer people. That could become a bit of a sticking point. I hope that is clarified. I am just here with Peter to support the bill and not let it be watered down.

**CHAIR:** Thank you, Max. Just out of curiosity, for how many years were you a practising anaesthetist?

**Mr McDonald:** Thirty-two years, and I was also in charge of intensive care for 13 years at the base so I have seen quite a bit in my time.

**CHAIR:** Thank you very much for the work you have done in your community. I say that because, from a paramedic point of view, we have to learn from those quiet people at that end of the patient who ventilate and intubate people. Thank you very much for your years and years of looking after people in the community. Thank you for your contribution.

**Ms KING:** Peter, you were saying that you are in aged care at the moment. Which aged-care facility are you in?

**Mr Belz:** [REDACTED] aged-care facility at [REDACTED].

**Ms KING:** I am not familiar with that one. Is that a religious or a state based one?

**Mr Belz:** It is run by the [REDACTED].

**Ms KING:** We have heard in these hearings that some religious based organisations would like changes made to the draft laws so that if somebody is living in a religious based facility like aged care they could be denied access to information or voluntary assisted dying because they lived in that facility. What would you think about that as a person living in that facility?

**Mr Belz:** In that particular facility for this particular person I do not think I would have too many troubles because at present I have the strength of body, as weak as it is, and the strength of mind, which is not weak. I do not think I would have a problem in that, because they are just so shit-scared of getting things wrong these days that it is not funny. I could see in other institutions where there could be pressures to either lean this way or the other. I am quite sure that there could be a bias in some of them, but, again, it is imagination over evidence.

**Ms KING:** Thank you so much for being here today.

**CHAIR:** Thank you so much, Peter, and thank you, Max.

**BLACKWOOD, Mr Darren, Private capacity**

**ROSS, Mrs Merle, Private capacity**

**Mrs Ross:** Good afternoon, committee, and thank you for the opportunity for me to speak. I was at the one a couple of years ago as well and I spoke. I find many problems with the VAD legislation, but in the time given I shall confine my comments to just a few. One serious flaw is the understanding of conscientious objection. A conscience is not appeased by telling the person where they can have their request fulfilled. Doctors and other medical people are not to be forced to compromise their understanding of ethics, their beliefs and their commitment under their graduating oath, spoken or implied: 'I shall do no harm ... Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course'. Telling a person where to go is thus contrary to the oath.

There is a second offshoot to being forced to facilitate killing rather than healing, or giving the patient to palliative care specialists, and that is, desensitising medical staff and the general public as well to death. It is like all things: doing something outside your comfort zone is very difficult the first time, less difficult the second time and so on.

By using the word 'voluntary', I suspect the government thinks that makes it watertight against abuse. That may be so for the initial years, but before long people will be agitating to have, first, some restriction removed which seems incongruous to their idea of compassion. Then in a few more years other restrictions will be deemed as illogical as well and so on. This is no idle conjecture. It is what has happened over years in places like Holland and Belgium, where euthanasia was legalised many years ago. We have the benefit of seeing how the reasons and the conditions have been relaxed to an alarming point. In short, once the absolute is breached there is no stopping its progress. The concept of 'voluntary' will be lucky to last 10 years.

Legalising VAD is teaching the population to see death as the answer to their problems instead of their seeing death as a point in life that we all pass through. Now the government is giving a choice of avenues to death; therefore, the government must make sure in the legislation that both palliative care and VAD be offered and explained in a fair and clear way.

Further, there should be three doctors: a specialist in mental health, a specialist in the illness and a third doctor well acquainted with the patient in a holistic way, and trusted, such as the patient's own GP. I know I always make my final decisions after going back to my trusted GP.

There has been mention of palliative sedation. The thing is whether the intent is on keeping the person comfortable in the process to death or whether the intent is killing the person. They might be the same process but it is the intent. Keeping the person comfortable through palliative care is what I support.

Consider also is it a good and noble thing to push aside Indigenous culture and other cultures and beliefs of people who had thought they had found a place of safety here, to establish a culture of death, as it has become known.

Finally, hard cases make bad law. This VAD law has been built on hard cases; therefore, it is inevitably bad law. I do not agree with it, but at least fix the known shortcomings before it goes to the final vote.

**CHAIR:** Thank you, Merle.

**Mr Blackwood:** Thank you for the opportunity. I thank all of you guys and girls for coming up here. It is good to see that you are going around to the public and actually listening to everyone around Queensland and hearing their views on this important issue. I drove back from Biloela. I am a coalminer. I was on night shift last night and I have a night off tonight to be here to listen to this, because it is fairly dear to my heart and I have strong views. I am a supporter of the VAD laws.

I want to talk about my own personal experience with my father-in-law. He was always a supporter of voluntary assisted dying. He was in a nursing home here in Rockhampton. All he ever wanted was euthanasia. He migrated after the war. He was from Germany. He was German. He suffered dearly in a retirement home here. He had an onset of Parkinson's and his organs were starting to shut down. Every breath was a struggle. He was on oxygen. We asked the medical practitioners to do what you do; you were talking earlier on about sedating people and increasing their dose. They would not do that. It was very distressing for all the family to go there. I personally refused to take my kids there anymore to see their grandfather. I could not go there myself. He deteriorated so bad. Every single breath was a struggle. That went on for about four days—no food, no water. He would just grab my hand and squeeze it that hard. He just wanted to die but they did not let him die.

Our last thoughts of his life are of that. You would have heard this right across Queensland, I assume. The last thoughts of the kids of their grandfather, my father-in-law, my wife's father, are terrible thoughts of what he went through, which he should never have gone through.

It has been really good and interesting listening to everyone here today and to hear the people who are against this, because everyone I talk to is for it. Out at Biloela, my uncles, my mother, my father and my work friends discuss it. I have not found anyone who is not for this VAD law. It has been really good to hear today from the people who are against it because it is the first I have heard it. It is good to hear the other side of the story.

In discussions with people around the community and so forth, we talk about life. Sitting here today, I heard a few people saying 'life is life' and so forth. What about the life of an animal? What do we do with our animals when there is pain and suffering? We do not ask to give them a needle and put them down. What do we do? We kill cattle, we eat sheep and everything else. Life is life: yes, it is. Are we being selfish in saying that our life is more important than any other life?

It is a choice. What we are asking for here is a choice to end your life, if it is terminal, in the right way. As Barry O'Rourke said earlier, we need to die with dignity. That is what I want. I know that is what my father wants, and a lot of people I talk to want that. I congratulate the Queensland Labor government for bringing this to a head—finally, because it has taken quite a while. It has been talked about for a while, but now we are here. I definitely would like to see it get up. Thank you.

**CHAIR:** Thank you very much, Darren, for sharing your own family story. Thank you, Merle and Darren, for your contributions today.

**WEBB, Ms Rhylla, Private capacity**

**Ms Webb:** Good afternoon. I am grateful and thankful that you people are here. I come from a long nursing background. I retired five years ago after 53 years as a registered nurse. In the last 25 years I was the director of nursing in rural, remote and regional facilities. I retired as the DON of the Capricorn Coast health service. During that time I was also a ministerial appointment in the Beattie government to the rural health advisory council. After listening to some speakers today—my colleague Paula, my colleague Professor Alan and Max McDonald, a previous colleague of mine—I thought I could contextualise some of your questions in relation to the palliative care network in Central Queensland. I was the DON of the rural central west based in Longreach. I have been based in Emerald, Gladstone—all over the place—and Indigenous. I was the director of nursing responsible for getting the organisational structure in place for the new Woorabinda health service back in 2000. I just want to put some context behind something.

In relation to the palliative care network, hub and spoke is of course the ideal. It is not there. Be very assured: we do not have it set up in a formalised fashion. Hub and spoke for palliative care support is not just medical care or nursing care; we need to have good integrated care. That means we do not have allied health support out there on the ground. Any palliative care that I accessed in my previous roles was through my personal networks. It was not through a formalised way of functioning. I think we are letting down regional and rural facilities in Queensland incredibly.

I also would like to address telehealth. We introduced telehealth in Emerald when it was very new. Putting telehealth in place is a wonderful thing and it is a wonderful tool in many instances. However, you need to have on-ground support at the time in rural areas. When we put it in in Emerald, it meant me having to get funding, write a business case, to get registered nurses who were trained in medical help to sit there with the patient and interpret what was happening in the telehealth scheme. It is not just a matter of picking up a phone; it is a matter of really good interpretation of the information that is given and the care that is given. Telehealth clinics are not things you can just pluck out of the air. You have to have good support, good funding, good training and nurses particularly who are able to interpret what is happening and support the patient and their family.

I would like to address conscientious objection. I have been so fortunate in my life to be in the profession I was in. Invariably it is a nurse who, with the mother, first hears the fetal heartbeat and rejoices. Invariably it is a nurse who feels the last pulse beat and grieves with the family. Throughout our nursing career, we are always faced with complex issues—complex things that could go against our own consciences. Yes, within the bill people can conscientiously object, but it is not that simple. The impost upon a nurse or any health professional in a team who has a conscientious objection to what is occurring in a unit they are working on makes their life very difficult, because the thing that binds a healthcare team together is that common goal. The common goal has always been alleviation of suffering and support of life. To see that, you only have to work in an emergency department. To see that, you only have to be out as the sole practitioner in a place like Boulia, where you and the QAS paramedic are the two working as a team. Understand very clearly: conscientious objection for a healthcare professional is not done in a bubble. It is not done in isolation. This bill—for or against it—I do not think has been fully considered in relation to the impost upon healthcare professionals.

**CHAIR:** Thank you very much. What an amazing career—53 years nursing in all of those communities! Thank you so much for your time in looking after those communities.

**Ms Webb:** I am eternally grateful to have had it. By way of full disclosure, I need to also tell you that I am Christian. I was chair of the Anglicare board here in Central Queensland for many years and currently am a member of Bishop in Council for the Anglican diocese.

**CHAIR:** Thank you very much for your significant contribution to the community.

**Ms Webb:** Thank you very much. I just wanted to contextualise.

**HOOPER, Mr Chris, Private capacity**

**Mr Hooper:** I believe in some sort of VAD. I have not followed the legislation, but anyway. All the problems associated with modern medicine are about keeping people alive longer. That is part of your problem, isn't it? COVID is a dress rehearsal for man induced climate change. You might have heard that from a few people around the place. My nickname is 'Pineapple'. I believe that the Queensland government introduced an act of parliament to get me out because I put the environment ahead of the economy. If we do not take notice of the environment, we are going to cause more deaths. You actually are doing a disservice by doing this. VAD is a very important thing, but if you do not look at the environment you will create more of this stuff. It is all going to backfire if you do not take control of it. That is about it, thank you.

**CHAIR:** I have no questions. Thank you very much, Mr Hooper.

**KENT, Dr Terrence, Private capacity**

**Dr Kent:** Thank you for giving me the opportunity to speak. I am a GP. I work in Ipswich, actually. I just happen to be up here on holidays. My wife is from Rockhampton. I do work at the Ipswich hospice some of the time and also with palliative care patients. I believe that a big part of the problem is the lack of proper palliative care in Queensland. I found it hard to believe that there are not hospices out of South-East Queensland, because the hospice in Ipswich is excellent. It is really amazing. The problem is that the failure in palliative care is necessitating the push for voluntary assisted dying. If we had proper palliative care, we would not need to look at it. That is my opinion.

There are so many issues involved. I have had patients who were told they had only a few months to live but who lived for quite a few years. Recently I even had one patient, 94 years of age, who was told he had terminal cancer. He was reassessed by a second specialist and he does not; it was the wrong diagnosis. You could have people dying who did not need to die. He is very happy!

As we have seen in other countries where assisted dying, euthanasia, has been legalised and it is open to abuse. It has happened in the Netherlands, Belgium and Canada. The legislation does have problems with conscientious objection. A lot of professionals think if they refer somebody it is the same as performing these acts themselves. That is a real problem. I believe that if doctors and nurses are permitted to take life then it is a real danger. At the moment we are only supposed to save life. I cannot see how voluntary assisted dying is not suicide or legalised murder, no matter who says it is.

**CHAIR:** Dr Kent, how long have you been practising?

**Dr Kent:** Over 30 years.

**CHAIR:** I respect that everyone has views, but what do you say to someone with advanced motor neurone disease—such as the gentleman at the back, Peter, from whom we just heard—who just wants choice at end of life and supports the bill? Why deny people choice who are clearly—

**Dr Kent:** I think that is a failure in the medical treatment. That is my opinion.

**Ms KING:** Dr Kent, I am familiar with the Ipswich hospice. I know what great work happens there. I am also well aware that the south-east corner of Queensland is well supplied with hospices, in comparison to the rest of Queensland, yet there are still a large number of people from the south-east corner who seek voluntary assisted dying. In fact, statistics from Oregon show that 70 per cent of people who request voluntary assisted dying are actually participants in our palliative care program at the time of seeking that access. Does that change your view that every request for voluntary assisted dying is a failure in medical care?

**Dr Kent:** I am not saying that palliative care in South-East Queensland is perfect. It is far from perfect. I think still the problem is that palliative care is not sufficient.

**Ms KING:** Would your view be that if even one person asked for voluntary assisted dying it would be that there was a failure of palliative care?

**Dr Kent:** Generally. I think you need to ask the specialists who are going to present in the next few days about that. Today you have given us the opinion of one from yesterday, but I think you need to get the opinions of the specialists who will be presenting in the next few days.

**CHAIR:** We heard from a lot of specialists in the former inquiry as well.

**Dr ROBINSON:** Dr Kent, firstly, let me say that I think we all acknowledge the importance of our GPs and the great work they do. The bill not having any requirement that the specialist be involved is a concern to some. Without in any way casting any aspersion on GPs, you alluded to a case or an example of a misdiagnosis of somebody. It happens from time to time. It is why we get second opinions and it is why we have specialists.

**Dr Kent:** Yes.

**Dr ROBINSON:** I have a great concern that the bar is low and, therefore, safeguards are not sufficient in this bill. That is a personal view based on listening to medical experts. Do you think there are other cases from time to time where very good GPs misdiagnose or maybe miss something and, therefore, we should be involving specialists as a requirement in the bill?

**Dr Kent:** I think that is the case, yes. That case that I mentioned was not a GP who made the misdiagnosis; it was another palliative care specialist. Everybody can make a mistake.

**Mr ANDREW:** Dr Kent, you said that other bills in other countries had morphed and changed. When you put a number on something, obviously that number can be changed or whatever.

**Dr Kent:** Most definitely.

**Mr ANDREW:** What do you think we should incorporate into this bill to stop that being perverted or changed in any way?

**Dr Kent:** I do not know what you would do. Once you give the power to people, I think human life gets devalued. I am not sure what you would do if you allowed this legislation to go through. I cannot see that it will not go down the slippery slope. Once again, that is my opinion.

**Ms PEASE:** Can I get some clarity. You are a GP who specialises in and visits the Ipswich hospice—

**Dr Kent:** No, it is not my specialty, but I do go there as a general practitioner.

**Ms PEASE:** So you visit patients in the Ipswich hospice?

**Dr Kent:** Sometimes.

**Ms PEASE:** Have you ever come across patients there who are at end of life?

**Dr Kent:** Yes.

**Ms PEASE:** What sort of medication do you give them? Do you give them palliative sedation to ease their pain?

**Dr Kent:** Yes.

**Ms PEASE:** What actually happens in terms of how that sedation works, if you would not mind explaining that to us?

**Dr Kent:** The medication does sedate them. I cannot see how that is assisting them to die but it is sedating them.

**Ms PEASE:** It sedates them in what way? So that they eventually pass away in their sleep; is that correct?

**Dr Kent:** They enter a stage where they would pass away anyway, but it sedates them.

**Ms PEASE:** With regard to those patients you are dealing with, have you engaged with them or spoken with them about whether that is what they want—that they want that pain relief that sedates them and sends them off to sleep?

**Dr Kent:** Yes.

**Ms PEASE:** So they are well aware that they are not going to wake from that?

**Dr Kent:** They would be told that, yes.

**Ms PEASE:** Regulating that to create more protections around that for patients: would you not see that as a good thing?

**Dr Kent:** But the intention is not to kill them, the way that things are done now.

**CHAIR:** It is the intent then, Doctor, to reduce their pain and suffering?

**Dr Kent:** Yes.

**CHAIR:** That is the double doctrine effect. That generally is spoken of, that the intent is to reduce pain and suffering. I go to a clinical question for a moment. Mostly and generally, those patients with terminal sedation are getting a range of opioids or morphine or fentanyl or ketamine or mirtazapine. What is the side effect when you start incrementally giving that?

**Dr Kent:** It may be that they pass away, but that is not the intention. It is quite different.

**CHAIR:** But there is an end point: the patient will pass.

**Dr Kent:** Possibly.

**Ms PEASE:** You would know that is going to be the outcome.

**Dr Kent:** They are usually fairly advanced. They are going to die anyway.

**CHAIR:** I think we have good clarification there. Thank you, Dr Kent.

### **TOMLIN, Ms Faye, Private capacity**

**Ms Tomlin:** I made a last-minute decision to speak with you. Today has been a very interesting day. I suppose I recognise that there seems to be a real overlap between this discussion around palliative care and voluntary assisted dying. I am actually a nurse practitioner specialising in palliative care. I work locally and have done so for many years. Probably I have been witness to well over 500 deaths and have been the primary treating clinician for the majority of those, in collaboration with my medical colleagues. I feel like I have a real grounding around this issue.

I want to be very clear that palliative care sits on one side and voluntary assisted dying is a whole separate issue. This is around respecting a person's choice to be autonomous: to be provided with compassion, understanding, good health information and good information about dying and to be provided that information in a way that allows the person to understand what their choices are and what their options are for care. I am a deeply respectful practitioner and, even when engaging with people around palliative care, I recognise this is a choice. Some people choose not to receive palliative care, to die in suffering. I respect that. I remain present with that person until the moment they die because being present is important, irrespective of what we choose to do or not do.

I declare that I am a supporter of voluntary assisted dying, in all the work that I have done. I am particularly deeply moved by the gentleman who spoke here today around motor neurone disease. We have a large number of community members here in Rockhampton and in the last month I have palliated two. It is a disease that is horrible. Certainly if I was ever in a situation I would not wish to be judged by anyone for making a deeply personal choice about what is right for me—not even God. I would be prepared to face God. I am my own person. I respect myself and I ask that others do the same.

There is just one thing that I wanted to bring to the attention of the committee. As a nurse practitioner I am a highly qualified nurse. I have undertaken enormous amounts of study. I work collaboratively, autonomously and independently in my role. I am a well-considered practitioner in the work that I do. When I was reading through this legislation I suppose I just sat back with my own discomfort at really being overlooked as a qualified and passionate healthcare provider who could assist and work collaboratively with my medical colleagues in the assessment process for people who wish to determine eligibility for this voluntary assisted dying legislation. I hope nursing is not overlooked. I really passionately ask you to consider.

There must be certain qualifications that a nurse reaches, but certainly I have been working as a nurse for 27 years. Even in my role in palliative care I must determine somebody's capacity, on a daily basis, whether they have that ability to move forward. In palliative care I liaise with psychiatrists on a regular basis because the journey towards dying is never easy. People do not fear death, in my experience; they fear living and they fear suffering. We are all part of this journey together as health professionals. I rely heavily on my colleagues and they respect me. I provide for them insight into the journey and it is one that you can only anticipate and understand having done this work every single day. I ask you to consider the role of the nurse. I am a highly qualified healthcare professional who could undertake assessment in this role.

I suppose there is one thing that concerned me and I suppose it is a little bit confusing in relation to the proposed legislation and the administration of substance and the term 'administering practitioner'. It was referred to there that a nurse practitioner or registered nurse with five years experience would be deemed suitable, but I paused. It would seem that nurses are suitable for the purpose of—if I put it plainly—'getting the job done', but there is more to a nurse than just getting the job done. I get the job done every day but I do that through a process of comprehensive assessment, through a process of deep and meaningful conversation with our consumers. This is not a job I take lightly, but I am not just about getting the job done. I have intimate relationships with those consumers. I believe very strongly in the role of the nurse in the support of the dying person, but we are not just about getting the job done. We are more than that.

I would like to see some respect for the advanced practice role in nursing and to be encouraged to join and collaborate with our medical colleagues in this. We must be together if this is going to be successful. We should not create a divide. In my experience, sometimes I must advocate for the person and sometimes it goes against the judgement of my medical colleagues, but I will do that every time. Let's not create a divide with legislation where we cannot be seen to be in partnership to do this work. I want that very, very much. I want us to be unified when we bring this forward for Queenslanders. They deserve unified legislation and health services that support every qualified health professional in this journey.

I also advocate strongly for mandatory psychological debriefing for any health professional who participates in this type of work. In my work in palliative care I undertake monthly self-care with a psychologist because I need to be sure I am in check. My husband reminds me every day, 'Faye, this is not normal business.' I appreciate that from him, because some days I am desensitised to death and dying. In the last two weeks we had seven people die very, very quickly, so dying just seems to me to be part of my everyday. I do not want it to be seen like that. I do not ever want to feel that way. I think it is really important and I advocate—whether it is a doctor doing this work or a nurse—that we must have mandatory debriefing, otherwise we all become a little bit too desensitised to the experience of dying.

**CHAIR:** Faye, you are an amazing individual who has just articulated the importance of the nurse and the role of delivering palliative care from a nurse practitioner point of view. I commend you for your years of service and being there in those moments, which must be incredibly difficult and challenging and personal sometimes when you go home.

**Ms Tomlin:** I did not come to this work; it seemed to draw me in, if I am honest with you. I can sit with the discomfort of other people's suffering and death in a compassionate way. That, I believe, is my gift. I do not know why, to be honest; it is just who I am. I am well trained and educated as a professional nurse to deal with whatever comes. I am respectful of everybody's journey. It is a real privilege to do this work. Unfortunately, we are still playing a little bit of catch-up. We are not as well supported as we should be. I am here to raise the voice for nursing, particularly the nurse practitioner, in the work that we could do for Queenslanders. We can improve their access to care. The most vulnerable people are the people we reach. We offer a flexible approach to day-to-day care, and that is what you need when you are dying. I come with absolutely no judgement. I sit with you, I hear you, I listen to you, and I offer you nothing more than myself.

**CHAIR:** I will ask the question why you support voluntary assisted dying, but I will put it in the context of those hundreds of people you have treated over the years who are terminally ill. In your view, when you see someone going through the dying process, have they shared with you that they just want to end it? Is there a reason that you support giving people choice? I do not know if you were here, but we heard from Dr Will Cairns, who has set up a lot of palliative care in Queensland. He thinks that all pain and suffering cannot be alleviated. He is also a supporter of giving people choice. What drives you to support that? Has your experience in dealing with people at end of life informed your decision?

**Ms Tomlin:** I have seen the very best of people and I have experienced the very worst. I understand the complexity of living until you die. I certainly recognise the difficulty of living with a life-limiting illness for everybody involved, not just the person who may die from the illness but also their family. For me it is very simple: every person deserves the right to make their own choice. I hope this does not sound a little callous, but it is irrelevant to me how a person dies in that I wish it to be on their terms, their choice. We all have that right as a human being. It is our human right to make our own choice.

The conversation in palliative care about whether pain and suffering can be alleviated I think, again, is about individual choice. Some people choose to die with pain. I know that may sound unbelievable, but it is the truth. Some people wish to feel the experience of dying. I do not think it is ever my job to create a euphoric experience for individuals at the end of their life. My role is to hear from them what it is they wish, and I am there to assist them with making choices and providing them with options of care.

I heard the discussion around palliative sedation. Palliative sedation is something that comes up from time to time, but isn't palliative care just about patient choice? Isn't it asking the person, 'What can I do for you to make you comfortable so you can transition and leave this world peacefully?' Whatever that person tells me, we speak about it openly, honestly and transparently. For some, it means no sedation at all; for others, it means a compassionate understanding that people feel the way they feel about the experience of their own life. We must be compassionate. My intention is never to end a person's life—I acknowledge that sometimes we make choices—but ultimately it will shorten their life because we are respectful and we wish to give them dignity. That is all I can do as a palliative care practitioner. If it is someone's choice to take voluntary assisted dying, then I wish it to be for them because this is their life, their choice.

**Mr MOLHOEK:** Faye, thank you so much for your comments and sharing your experience with us today. I was given a very short shrift education about the role of nurse practitioners when I was invited to speak at their conference earlier this year on the Gold Coast. I had to admit that I had no

idea what the role of a nurse practitioner is, but I now have a very clear understanding of your role. I take on board your comments today. I want to assure you that we have heard what you have had to say today.

I should point out the important role that you and your colleagues play here in Central Queensland, because I know that down at the Yeppoon Hospital the clinic that was built to provide space for GPs to come and provide outpatient services would not function if we relied on GPs, because there aren't any. I know that service is 100 per cent supported by people like yourself. I just want to put on record the incredible role and contribution that you all make. Thank you for your contribution today.

**Ms Tomlin:** Thank you very much. I really appreciate your time and you all coming to Rockhampton to allow us as a community to speak with you face to face.

**CHAIR:** That concludes today's proceedings. I thank everyone for their contribution today. We had people observing in the audience throughout the entirety of this afternoon. We do really appreciate the opportunity to come to Rockhampton to hear the views and contributions of people. I now declare this public hearing closed.

**The committee adjourned at 4.23 pm.**