

Hon Aaron Stonehouse; Hon Stephen Dawson; Hon Nick Goiran; Hon Rick Mazza; Hon Adele Farina; Hon Martin Pritchard; Hon Alison Xamon; Hon Alannah MacTiernan; Hon Tjorn Sibma; Hon Jacqui Boydell; Hon Simon O'Brien; Hon Martin Aldridge

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 20 November. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Progress was reported after the clause had been partly considered.

The DEPUTY CHAIR: Minister, do you want to make any opening remarks before we commence?

Hon Stephen Dawson: No.

Hon AARON STONEHOUSE: I note that the language used in clause 9 is “registered health practitioner who has a conscientious objection” and that the title of the clause is “Registered health practitioner may refuse to participate in voluntary assisted dying”. This obviously points to a very specific group of people—registered health practitioners—as opposed to the looser language used in earlier clauses, such as “health practitioner” or just perhaps a “medical practitioner”. I wonder whether under this bill there is any ability for a non-registered health practitioner who may otherwise be involved in the regime of voluntary assisted dying to be a conscientious objector and to refuse to take part in the process. I am thinking about perhaps a receptionist at the front desk of a medical clinic, who perhaps does not want to have anything to do with voluntary assisted dying, or social workers, who are not registered health practitioners but who are referred to, by the minister’s own admission, in the principles of the bill.

Hon STEPHEN DAWSON: The reason that clause 9 refers just to registered health practitioners is that they have particular roles set out under this bill. There is no obligation on anyone to participate. In relation to the issue concerning a receptionist, that would need to be managed between that person and their employer. The bill does not give non-registered health practitioners the protection. There is a wider ability in common law, but it is not enshrined in this bill.

Hon AARON STONEHOUSE: I might have some questions about the common law right to conscientious objection later—that is something I am really interested in and will unpack in detail in a moment. What I am thinking about is an instance in which a social worker is working in palliative care. The minister says that the bill does not place any obligation on them to be involved in voluntary assisted dying. If they are not a registered health practitioner, there is no obligation on them to be involved in this scheme.

Hon Stephen Dawson: By way of interjection, what I indicated was that they have no particular role set out in this bill.

Hon AARON STONEHOUSE: There is no role for them set out in this bill, so the bill places no obligation on them to participate in voluntary assisted dying. That is good; I am glad to hear that. Another scenario I am concerned about is that of a receptionist at a doctor’s clinic. The bill does not place an obligation on them to be involved in voluntary assisted dying. However, there may be an obligation placed on them in their employment contract that would somehow involve them in the voluntary assisted dying regime. For example, when a doctor processes someone’s application, their receptionist will be involved in that to some degree. Is it true, then, that there may be an obligation, perhaps through someone’s employment contract, for a non-registered health practitioner to be involved in voluntary assisted dying?

Hon STEPHEN DAWSON: It is possible, honourable member, but I guess it would be highly unlikely that someone’s contract, a receptionist for example, stipulates that they must be involved in the voluntary assisted dying process. If somebody was about to start a job, they could at that stage say they were not signing the contract because there was an issue in there they do not believe in, and that would be their right. I reiterate that a receptionist does not have an obligation under this bill before us.

Hon AARON STONEHOUSE: I am not saying it is a good or a bad thing; I just think it is worth being completely clear about the obligations people will have to be involved in the voluntary assisted dying regime. To make my view on this clear, I absolutely believe that medical practitioners should be afforded a right to be conscientious objectors; everybody should. However, somebody who voluntarily enters into a contract with an employer has obligations under that contract. That is a voluntary arrangement they have as well. They are not coerced into becoming an employee at a clinic that provides voluntary assisted dying, of course; however, there is the issue of retrospectivity here, I suppose. There is no obligation for, say, a receptionist or some kind of support worker to be involved in the voluntary assisted dying regime in this bill; however, a medical practitioner processing a voluntary assisted dying request may involve their support staff or receptionist in some way; for example, by asking them to

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photocopy documents or to bring up Mrs Henderson's file for her VAD request—something like that. They may be involved in that process to some degree.

Hon Nick Goiran: They could even be a witness to the VAD.

Hon AARON STONEHOUSE: They could perhaps even be a witness to practitioner-administered voluntary assisted dying. That is not a requirement or an obligation placed on these people under the bill, but it may be an obligation under their employment contract, which is what I am getting to. An employer hires somebody with the understanding that they will process paperwork for them—before VAD even existed. Once VAD has been passed, their obligations will still be the same—to process paperwork as a receptionist or in an administrative role. Therefore, those people may now have an obligation as employees to continue to carry out that function of processing paperwork or perhaps even being witness to practitioner-administered voluntary assisted dying. Can the minister clarify whether I am on the right track here? There may be an obligation, not through the bill, but merely through the relationship an employee has with an employer. Again, I am not saying this is good or bad. My personal view is that the person can quit if they do not like it. If a person's employer is administering voluntary assisted dying, they are under no obligation to remain an employee of that employer. If I were an employee of someone administering voluntary assisted dying—I do not personally like the idea—I would quit. I would not be an employee there anymore and it would be absolutely my right to disassociate from people who administer VAD.

Hon Alannah MacTiernan: Do you support the principle of VAD?

Hon AARON STONEHOUSE: I do. I support the principle. We will wait to see what the bill looks like at the end of the Committee of the Whole House.

Hon Alannah MacTiernan: You would not be someone who resigns from their job.

Hon AARON STONEHOUSE: I would. I personally do not like voluntary assisted dying. I would not advocate it for anybody I know; I would try to talk them out of it. But I do not want to use the state to coerce people into living their lives by my standards. I have a personal objection to it, but I do not think I should refuse other people the right to access it if they really want to.

Hon Alannah MacTiernan: Good to hear!

Hon AARON STONEHOUSE: I think that is a pretty standard classical liberal view of this stuff.

Just to get back to the question I was asking the minister, who I think is seeking advice now, it is good to say that new employees would look at their employment contract and the practices of their new employer. They could see that the employer processes VAD applications and decide they do not want to work for them. That is fair enough. What about people who are currently employed, whose current obligations as an employee may put them in a position of being directly involved with voluntary assisted dying in some support or administrative role?

The DEPUTY CHAIR (Hon Dr Steve Thomas): Just before we go on, Hon Aaron Stonehouse, it was mentioned last night that the undertone of conversation around the chamber was an issue. It has just risen again, and I can hear it, so I ask members if they could take their conversations outside to allow Hon Aaron Stonehouse to make his contribution in silence.

Hon AARON STONEHOUSE: I think I have made my question clear, but if the minister needs more clarification, he should let me know.

Hon STEPHEN DAWSON: The employee would still have the ability to refuse to witness a document related to VAD. If the medical practitioner said that they were going to sack the receptionist, that would be an industrial relations matter. Obviously, if a doctor took that action, the receptionist could take recourse under the Industrial Relations Act 1979. Because a doctor can conscientiously object to participate in VAD, I think it would be unlikely for a medical practitioner to sack a staff member, such as a receptionist, who refuses to witness a document. It could happen. In that case, the receptionist could take industrial relations action.

Hon AARON STONEHOUSE: This is rather interesting. The minister raised something that I had not expected. I would not have thought that an employee refusing to witness or process a document because of an objection to VAD would be grounds for some kind of unfair dismissal suit or arbitration at the Industrial Relations Commission. That raises an issue. A medical practitioner may be planning to be a provider of voluntary assisted dying and to process requests, and perhaps they will have an employee who is a conscientious objector, which they obviously have every right to be. If that conscientious objector employee says, "I am not going to do my job related to these requests; I am just going to sit on my hands and refuse to participate", that creates a bit of an issue. If the employer has no way to oblige their employee to carry out their normal functions of processing paperwork and carrying out

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administrative tasks, and they fire them, they are liable for an unfair dismissal suit. I think we have a bit of a problem that needs to be looked at closer.

Hon Stephen Dawson: It would depend on the circumstances, but certainly in some cases, there could be an IR case.

Hon AARON STONEHOUSE: I understand the argument from the other side that that might counter some kind of religious discrimination—say, a Christian employee who refuses to carry out their role because they have a conscientious objection and that person's religious freedom should be protected. I am absolutely a believer in religious freedom and the right to be a conscientious objector, but if someone refuses to do their job, an employer should not be obliged to continue hiring that person. I think this cuts both ways. I am an advocate of freedom of association when it comes to other institutions. For instance, I think religious institutions should not be obliged to hire people who do not subscribe to their specific set of values. I think there should be exemptions and discrimination through Christian schools, religious schools and other religious institutions so they can hire and fire as they please. But it cuts both ways. I believe in freedom of association for all people.

The minister is saying that it would depend on the specific circumstances. I do not have enough experience in IR law. Perhaps other members who are familiar with this area might want to interrogate that further. I am interested in pursuing a couple of other lines. I might resume my seat for a moment while I prepare for a different line of questioning.

Hon NICK GOIRAN: I am intrigued by this line of questioning by the honourable member. I ask the minister to look at the three elements in clause 9(1). Under clause 9, a registered health practitioner will have the right to refuse to do three things on the basis of a conscientious objection. The first is to participate in the request and assessment process; the second is to prescribe, supply or administer a voluntary assisted dying substance; and the third is to be present at the time of the administration of a voluntary assisted dying substance. Notwithstanding clause 9, does every Western Australian have that right?

Hon STEPHEN DAWSON: I am told that every person has the right to refuse, but that right to refuse may be affected by the person's contractual obligations.

Hon NICK GOIRAN: Let us take the third limb. Notwithstanding clause 9—let us assume for a moment that clause 9 is not in the bill and has been defeated—would every Western Australian have a right to refuse to be present at the time of the administration of a voluntary assisted dying substance? Neither the minister nor I are registered health practitioners in this state. I want to know that both the minister and I have the right to refuse to be present at the time of the administration of a voluntary assisted dying substance.

Hon STEPHEN DAWSON: My advisers tell me yes.

Hon NICK GOIRAN: That deals with the third limb, so we can go backwards. Every Western Australian has a right to the third limb, not just registered health practitioners. That is very comforting to know. Looking at the second limb, does every Western Australian have the right to refuse to prescribe, supply or administer a voluntary assisted dying substance? I know that only certain Western Australians have the power to do those things. That is a different question. I am not asking who has the power to prescribe, supply or administer. I want to know whether every Western Australian has a right to refuse to prescribe, supply or administer a voluntary assisted dying substance.

Hon STEPHEN DAWSON: Yes, honourable member.

Hon NICK GOIRAN: We now know that every Western Australian has the right to refuse to be present at the time of the administration of a voluntary assisted dying substance and we also know that every Western Australian has the right to refuse to prescribe, supply or administer a voluntary assisted dying substance. My last question on this theme is: does every Western Australian have a right to participate in the request and assessment process?

Hon STEPHEN DAWSON: They have the right to refuse. I am just clarifying that. The member asked the opposite, but I am clarifying that.

Hon NICK GOIRAN: In light of that, if every Western Australian has the right to refuse these three limbs—I want to be clear that I support that—why does this clause refer just to a registered health practitioner and not any person?

Hon STEPHEN DAWSON: It is in here because a statute overrides common law and contract law.

Hon NICK GOIRAN: Yes, that is right. That is why I think it should be "any person in Western Australia". I will give the minister a practical example. I think the minister will agree with me that in this bill, "registered health practitioner" does not include students. I will give the minister a practical example of a medical student. Medical students will not be protected by this statutory right, but I think that they should be. Why should a medical student, who would be in a lesser position in the power and influence relationship between a student and a supervisor, have to feel any pressure whatsoever to be present at the time of administration of a voluntary assisted dying substance?

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I think we can imagine a scenario in which a VAD practitioner, if I can call them that, is going to administer the substance and needs a witness, and some form of coercion, undue influence or even subtle pressure is put on a medical student to participate in the process by being present. It strikes me that a statutory right at clause 9(1) for any person would be superior to saying a “registered health practitioner”. This is piggybacking off the line of inquiry raised by Hon Aaron Stonehouse, who was talking about receptionists and others who might be involved with forms. I guess I am taking it to the next level and asking about medical students. Should they not have the same right to refuse to participate in all this?

The other example I want to give the minister is pharmacists. Perhaps the minister can indicate whether pharmacists would be captured by clause 9. I note that section 7 of the Victorian legislation provides that practitioners who have a conscientious objection to voluntary assisted dying have the right to refuse to provide information about voluntary assisted dying. Of course, our bill will not give them that right. I am a bit concerned about various categories of individuals: first of all, medical students; workers in medical practices, whom Hon Aaron Stonehouse referred to; and pharmacists, pharmacy assistants and other persons involved in pharmacy work. Perhaps the minister can clarify whether those people will be covered by this provision. It is clear to me that medical students will not be covered, but I am not as clear about pharmacists or pharmacy assistants.

The DEPUTY CHAIR: Before I give the call to the minister, I again remind members that we need a relatively high degree of silence in the chamber for the minister to be able to communicate with his advisers.

Hon STEPHEN DAWSON: Medical students will not have a role under this bill, so they have not been identified in this clause. A registered pharmacist could object or refuse to participate.

Hon NICK GOIRAN: I take it that a registered pharmacist is a registered health practitioner. What about a pharmacy assistant or another person employed in pharmacy work? Should they also have the right to refuse to participate in any of this, particularly the supply of a voluntary assisted dying substance? I note that this appears at section 7(f) of the Victorian legislation. Our legislation does not include that provision. Section 7(f) of the Victorian Voluntary Assisted Dying Act provides health practitioners who have a conscientious objection to voluntary assisted dying with the right to refuse to dispense a prescription for a voluntary assisted dying substance. The minister has indicated that pharmacists are covered because of the registered health practitioner definition, and I accept that, but we do not have the same provision as that at section 7(f) of the Victorian legislation. Is the minister indicating that the dispensing is covered by clause 9(1)(b)?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: I think that will give comfort to pharmacists, but it will not give comfort to pharmacy assistants and other persons working in pharmacies. Firstly, should they have the same right to not participate in the supply of the substance? I go back to my earlier point: I still think that every Western Australian should have a statutory right to not be present at the time of the administration of the voluntary assisted dying substance.

Hon STEPHEN DAWSON: I do not think that this is the honourable member’s point, but a pharmacy assistant cannot supply. The pharmacist has to supply or dispense the voluntary assisted dying substance. That could then be handed to a pharmacy assistant or someone on the register, and they would have to participate. The member’s question is about that, not necessarily the supply or dispensing of it.

Hon Nick Goiran: I suppose it is how we define or interpret “supply”, isn’t it?

Hon STEPHEN DAWSON: Yes, but my advisers tell me that the “supplying” or the “dispensing” is done by the pharmacist. I clarify that the member’s issue is about anybody in the chain, if I can use that terminology, and their ability to conscientiously object or opt out. They have a common law right to refuse to participate or object. If a student, pharmacy assistant or register worker is pressured in the way suggested, this could constitute misconduct by the practitioner pressuring them. Further to our supply issue, I am told that supply is defined as per the Medicines and Poisons Act 2014. That is a peripheral issue. At the moment, they have a common law right, and then, if they were being pressured, this could constitute misconduct by the practitioner pressuring them.

Hon NICK GOIRAN: In light of that, I move —

Page 10, line 4 — To delete “registered health practitioner” and substitute —
person

By way of explanation, this amendment simply gives effect to the dialogue we just had. Hon Aaron Stonehouse raised an important issue about conscientious objection. I am grateful to the minister for confirming that every Western Australian has a right to refuse to participate in the three things that are set out in clause 9 and that Western Australians have that as a common law right. This will simply put it into legislation to make it clear that every Western Australian, not just registered health practitioners, has that right.

Extract from *Hansard*
[COUNCIL — Thursday, 21 November 2019]
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Hon STEPHEN DAWSON: I appreciate the debate that we have just had. We are not supportive of that change. The reason “registered health practitioner” is in clause 9 is that they have particular roles set out under this bill. That is why it is limited to registered health practitioners, so we do not support the member’s proposed deletion and insertion.

Hon RICK MAZZA: I rise to say that I will be supporting the amendment. I genuinely believe that any person involved in the process, health practitioner or not, has a right to refuse to participate if it is something that they do not want to do. I am most supportive of this amendment.

Division

Amendment put and a division taken, the Deputy Chair (Hon Dr Steve Thomas) casting his vote with the noes, with the following result —

Ayes (10)

Hon Martin Aldridge	Hon Simon O’Brien	Hon Aaron Stonehouse	Hon Ken Baston (<i>Teller</i>)
Hon Nick Goiran	Hon Martin Pritchard	Hon Colin Tincknell	
Hon Rick Mazza	Hon Charles Smith	Hon Alison Xamon	

Noes (23)

Hon Jacqui Boydell	Hon Colin de Grussa	Hon Colin Holt	Hon Matthew Swinbourn
Hon Robin Chapple	Hon Sue Ellery	Hon Alannah MacTiernan	Hon Dr Sally Talbot
Hon Tim Clifford	Hon Diane Evers	Hon Kyle McGinn	Hon Dr Steve Thomas
Hon Alanna Clohesy	Hon Donna Faragher	Hon Michael Mischin	Hon Darren West
Hon Peter Collier	Hon Adele Farina	Hon Samantha Rowe	Hon Pierre Yang (<i>Teller</i>)
Hon Stephen Dawson	Hon Laurie Graham	Hon Tjorn Sibma	

Amendment thus negated.

Hon AARON STONEHOUSE: Minister, I am concerned about the right of not only registered medical practitioners but also, for want of a better word, institutions or organisations to be conscientious objectors. I am thinking particularly about a hospital where the practitioners and employees may be conscientious objectors for religious reasons or otherwise. Will that organisation have a right to be a conscientious objector and not involve itself in the VAD process, or will that right extend only to individual employees, board members or the CEO?

The DEPUTY CHAIR: Again, members, there is a degree of chatter around the room. I ask you to keep that quiet. The minister has the call.

Hon STEPHEN DAWSON: Hospitals are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility. Clause 113 protects doctors from being found to have breached principles of conduct applicable to the person’s employment. The government would be deeply disappointed if health organisations discriminated against employees or contractors for undertaking what would be a lawful end-of-life treatment.

Hon AARON STONEHOUSE: Thank you for that, minister. There is protection under clause 113 for a medical practitioner who is a conscientious objector and breaching their obligations under their employment contract with a hospital. It may not be a hospital; I suppose it could be an aged-care facility or even a palliative care facility or something like that. That is good to know.

I would like to turn now to clause 9 and look at the protections provided there and how they work with later obligations under clauses 19, 20 and 21, which are most of the provisions within division 2 of part 3. I would like to highlight what I see as a contradiction. I am sure the Minister for Health would disagree, but I really do see this as a contradiction. Clause 9 creates a sort of absolute right, which builds upon what is already understood in common law to be a right to be a conscientious objector. It puts it in statute—in the written law—to protect it. Clause 9(1) states —

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

- (a) participate in the request and assessment process;

However, clause 19(5) states —

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If the medical practitioner refuses the first request because the practitioner has a conscientious objection to voluntary assisted dying, the practitioner must, immediately after the first request is made —

- (a) inform the patient that the practitioner refuses the request;

I have no complaint there; that makes sense. It continues —

- (b) give the patient the information referred to in subsection (4)(b).

That refers to the information approved by the CEO about voluntary assisted dying. Although an absolute right is created in clause 9, it is contradicted by clause 19(5)(b) by putting an obligation on registered medical practitioners to provide information. Therefore, they do not in fact have a right to refuse to participate in a request and assessment process; they are obliged to participate in that process. We might say that that is a rather minor obligation and all they have to do is provide information, but it is still an obligation to be involved in that process. It is completely contradictory to that absolute right created in clause 9. I am sure the minister will say that he has read the *Hansard* of the lower house debate and that it is a general principle that gives way to a specific obligation. It is all good and well to say that, but it makes me really wonder what is the point of even having clause 9(1)(a). Why even have that in there? Why even say that someone has a right to not do something but then put a specific obligation on them to do that? It completely contradicts itself.

Clause 20 states that a medical practitioner has to record the first request and their acceptance or refusal. Again, these are further obligations on a registered medical practitioner to be intimately involved in this process. Medical practitioners have an obligation to notify the Voluntary Assisted Dying Board of the first request. Some of these obligations may have more merit than others. We certainly want some oversight of this if patients are doctor shopping, so to speak. We would probably want the board to know about that. I know that there is no prohibition on that and that it is absolutely the right of a patient to do that if they would like to seek a second or third opinion. As far as I am concerned, there should not be a prohibition on that. But it seems to me that clause 9 and the obligations created in division 2 of part 3 are contradictory. Whatever rights are created in clause 9 are completely blown away by the obligations in clauses 19, 20 and 21. It makes me really wonder what is the point of having such a right written in statute in the first place. What does it mean to have a right to do something if it is written away in a later clause? I will have a bit to say about the rights of conscientious objectors when we get to division 2, of course, as those clauses are completely contradictory.

That leads me to a question, minister. What is the penalty for a real conscientious objection of a medical practitioner who genuinely refuses to take part in voluntary assisted dying? We have the sort of pretend rights of conscientious objectors in clause 9, but they do not really count for anything. We could probably do away with clause 9 entirely and I do not think it would make any difference to the bill at all. We already have a common law right to be a conscientious objector. What are the penalties for someone who is a real conscientious objector—not a pretend one who still has obligations under later clauses—who refuses to provide information prescribed by the CEO? What would happen to a doctor who has for religious or other reasons a conscientious objection to VAD, who when a patient requests voluntary assisted dying says, “I’m sorry that is against my personal beliefs and I’m not going to help you do that”, and does not provide the information that the CEO wants them to? What would happen to that medical practitioner?

Hon STEPHEN DAWSON: First, giving information is not participating in the process; it is a very different thing. It is a statutory right but not to the exclusion of statutory obligations in the bill. In any case, acceptance or refusal, the medical practitioner is required to provide the patient with information approved by the CEO for the purposes of clause 19. Objectors must still provide general information about voluntary assisted dying. Failure to notify the patient within the specified time frame would be a contravention relevant for consideration under clause 10, “Contravention of Act by registered health practitioner”. That the patient’s decision is well informed is fundamental to the proposed model for voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: Part 3 of the bill is titled “Requesting access to voluntary assisted dying and assessment of eligibility”. Is the first request, which is set out at division 2 of part 3, part of the request and assessment process?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: The minister just told Hon Aaron Stonehouse that providing information is not part of the process. I think the honourable member is raising a very legitimate concern. Clause 19(5)(b) says that we are creating an obligation on a medical practitioner, who incidentally is a registered health practitioner, to “give the patient information referred to in subsection 4(b).” The honourable member is absolutely correct. On the one hand, this bill says at clause 19(5)(b) that we will force, we will oblige, medical practitioners in Western Australia to provide information—the minister just indicated to me that that is part of the first request and part of that process—

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but on the other hand, it says that they have a right to refuse to do any of these things. I draw the minister's attention to clause 9(2), which specifically says —

Subsection (1) is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection.

That is about as inconsistent as we are ever going to get in a piece of legislation. My question to the minister is which clause prevails? Does clause 9(2) or the clause that concerns Hon Aaron Stonehouse, clause 19(5)(b), prevail? Which one prevails?

Hon STEPHEN DAWSON: If I can just clarify. Standardised information regarding the voluntary assisted dying process, for example eligibility criteria, access points, supports and that a patient's consent to assisted dying may be withdrawn at any time, will be developed during the implementation stage and be made available to all health practitioners for provision to persons who make a request or require information regarding voluntary assisted dying. This information will help the person access the relevant resources and supports they need to participate in the process. The provisions of clauses 9 and 19 are consistent with the Australian Medical Association's position statement on conscientious objection, specifically in relation to the provision of information as per part 2.3 of the AMA position statement, which states, in part —

A doctor with a conscientious objection, should:

- inform the patient of their objection, preferably in advance or as soon as practicable;
- inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
- take whatever steps are necessary to ensure the patient's access to care is not impeded;

I would further say that, as with all legislation, the general must give way to the specific.

Hon NICK GOIRAN: Which clause prevails?

Hon STEPHEN DAWSON: I am told they are not inconsistent, so neither prevails.

Hon NICK GOIRAN: If a medical practitioner in Western Australia picks up this bill and reads clause 9(2), they will read —

Subsection (1) is not intended to limit the circumstances in which —

I, the registered health practitioner —

... may refuse to do any of the things referred to in that subsection.

I—that medical practitioner in Western Australia—say, “Well, section 9(1) says that I've got the right to refuse to participate in the request and assessment process.” I then go to clause 19(5)(b), which provides that I am supposed to give some patient some information: “Well, that's okay, I don't need to do that because I'm going to rely on 9(1) and (2)”. Is that an option for a medical practitioner in Western Australia?

Hon STEPHEN DAWSON: The specific is clause 19, so they must give the information.

Hon AARON STONEHOUSE: The minister pointed me towards clause 10 for penalties that might apply to a medical practitioner who is a conscientious objector. I am looking at clause 10, but there is no mention of penalties; instead, it points me to the Health Practitioner Regulation National Law (WA) Act. Can the minister tell me what the penalty is under that legislation for the contravention of a provision of this legislation by a health practitioner who is a conscientious objector and refuses to provide information under clause 19(5)(b)?

Hon STEPHEN DAWSON: I am told that the Australian Health Practitioner Regulation Agency could investigate the matter, and it could do a number of things. If it found a range of things, it could take action as a result. Examples could include a caution, a suspension, a reprimand, or, indeed, cancellation of registration.

Hon AARON STONEHOUSE: Are there other penalties, such as fines or imprisonment?

Hon STEPHEN DAWSON: Can the member just clarify the question? Is he asking about penalties under the Australian Health Practitioner Regulation Agency process?

Hon AARON STONEHOUSE: If someone contravenes a provision of this bill, what penalties will they be liable for? Obviously, I am specifically interested in clause 19(5)(b). The minister mentioned that there might be a reprimand, or loss of licence. Are fines or imprisonment available as penalties for medical practitioners who contravene this legislation? If it helps to narrow down what I am looking at, it was mentioned in the debate on this clause in the Legislative Assembly that there is a \$10 000 fine for medical practitioners who do not carry out their obligations under clause 19(5)(b).

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Hon STEPHEN DAWSON: I thank the member for clarifying that. We were looking at documents in relation to AHPRA, and other things as well, so I appreciate the member bringing that to our attention. As the bill currently stands, failure to give a form to the board following a first request may result in a fine of \$10 000. That is under clause 107 of the bill.

Hon AARON STONEHOUSE: That is the penalty for failing to notify the board. Would the same penalty apply for failing to provide information to a patient under clause 19(5)(b)?

Hon STEPHEN DAWSON: I am told that failure to provide information is captured in clause 10. The person would not get that \$10 000 fine.

Hon AARON STONEHOUSE: I thank the minister for that clarification. The \$10 000 fine is for failure to notify the board. However, it still gets to what I see as a failure to protect conscientious objectors. A conscientious objector who refuses to take part in this process is still obliged to provide information to the board, for an application they have not even processed. They have refused flatly from the outset. A person may walk into someone's general practice and say, "Doc, I want to access VAD", and the doctor says, "Sorry, I'm a religious person; I'm not your doctor; go elsewhere", and they have to notify the board. They do not even know who the person is. They have just walked in off the street, and all of a sudden they are a patient, as defined in the terms of this bill, and there are obligations on that medical practitioner to notify the board—of what?—"Some guy walked in and asked for VAD, and I said no." They are obliged to provide information as well. In that case, there is a \$10 000 penalty for failure to notify the board. When we get to division 2, I will have a lot to say about how a medical practitioner is meant to even record that on someone's medical record when they do not know who the person is. In order to be a patient, all a person has to do is make a request. A person does not need to have any kind of therapeutic relationship with a medical practitioner in order to be a patient under this bill. However, I will leave that for when we discuss division 2 of part 3.

For now, I would like to highlight what I think is a great imbalance; we are creating two types of obligations for different health practitioners. A registered health practitioner will, apparently, have the right to be a conscientious objector—although we know that that is not true; they will have extra obligations that come with that—and then all other health practitioners will have no such obligation. The right to conscientious objection will be protected under common law and they will not be obliged to notify the board or provide information. Someone will be able to ask a social worker at a palliative care hospice about VAD, but they will be under no obligation to provide information or notify the board, as I understand it. I am happy to be corrected, if I am wrong. However, if a person asks a Chinese herbal therapist about VAD, all of a sudden that person who sells someone ginseng will have to provide information about voluntary assisted dying and notify the board. It is an absurdity that that absolutely insane obligation will be put on registered health practitioners. For a start, I think it is ridiculous that people such as Chinese herbal medicine practitioners and dispensers, chiropractors or acupuncturists are registered medical practitioners; as far as I am concerned, they are probably all quacks. But they are registered health practitioners and they will have an obligation under this legislation. Someone could get a rubdown and ask their occupational therapist about VAD.

Hon Nick Goiran: Can I make the observation that those obligations, if you look at clause 19, talk about medical practitioners, and they use different language there. It talks about "medical practitioner" compared with "health practitioner".

Hon AARON STONEHOUSE: I know an amendment on the supplementary notice paper will tidy up things, but we have not got to that yet.

Hon Stephen Dawson: It would be good if you contained your comments to clause 9, because there are other things for discussion later on.

Hon AARON STONEHOUSE: I understand that and I look forward to the opportunity to tidy that up a little bit when we discuss proposed new clause 9A. However, we are still creating a two-tiered system. Some people in the health profession will have no obligation at all, but registered health practitioners will. In this case, a person at a lower level will have more of a right to be a conscientious objector than will a registered medical practitioner. I think that is a little disgusting, to be honest. Some people will have more rights than others under this regime.

I understand, obviously, that we want to ensure the rights of patients are protected and that patients will not be coerced, but who has given consideration to the coercion of medical practitioners? Everybody is very concerned about limiting coercion. No-one should be forced into voluntary assisted dying if they do not want to. We are being very careful to stress that this is a voluntary regime, but it is voluntary for all but one class of people—that is, registered medical practitioners. There is nothing voluntary involved for them. They can either continue to be doctors or hang up their hat. Unless they want to face a \$10 000 fine or lose their licence, they have no other choice, I suppose. If they are genuine conscientious objectors, they will have to hang up their stethoscope, close down their

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practice and leave the medical profession. I really hope that does not happen; it would be a tragedy. But that is what we are looking at here: a lack of adequate protection for real conscientious objectors and very much a two-tiered system in which some people will have more rights than others.

Hon NICK GOIRAN: Minister, given the dialogue that has taken place on clause 9, it is not clear to me what we are doing for the benefit of registered health practitioners by virtue of this clause. If, as we agreed earlier, every Western Australian will have the capacity to refuse in respect of those three limbs, what is being done by clause 9 that will help registered health practitioners other than, if you like, stating the bleeding obvious?

Hon STEPHEN DAWSON: This clause of the bill will enshrine the rights of registered health practitioners to conscientiously object or otherwise refuse to participate in the steps reasonably related to voluntary assisted dying. We have had a debate on this now. The member might have a different view from me, but that is what it will do and that is why we are saying that this clause is needed in the bill.

Hon NICK GOIRAN: I have compared and contrasted clause 9 of this bill with the similar provision in the Victorian legislation, which is section 7. The Victorian provision has six limbs on conscientious objection whereas we have only three. The minister has confirmed that the sixth of those limbs is covered by the second one in this bill. Under section 7(f) of the Victorian legislation, a practitioner is not obliged to dispense a prescription for a voluntary assisted dying substance. The minister's advice to the house is that that is already covered by clause 9(1)(b) because it refers to "supply". I am happy to accept that advice, notwithstanding the fact that the fourth limb of the Victorian provision uses the same words as those in clause 9(1)(b), where it states —

to supply, prescribe or administer a voluntary assisted dying substance;

I guess what the minister is saying to us is that the sixth limb of the Victorian provision is unnecessary because it is already covered by the fourth limb. I just draw to the attention of members that the Victorian legislation states at section 7 —

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

The very first of those limbs is —

(a) to provide information about voluntary assisted dying;

Why was it decided not to include that limb in clause 9?

Hon STEPHEN DAWSON: Section 7(a) of the Victorian act states that a registered health practitioner who conscientiously objects does not need to provide information about voluntary assisted dying. This government made a conscious choice to exclude that. There was a discussion of this by the Ministerial Expert Panel on Voluntary Assisted Dying. On page 52 of the report, it states —

In considering the feedback provided through consultation and in reaching its position on this topic the Panel was guided by the core principle that the person should be fully informed about voluntary assisted dying and all other options before formally requesting voluntary assisted dying.

If legislation is passed to enable voluntary assisted dying in Western Australia the panel noted the relevance of the principle that a person should not be impeded in accessing what would be a legal option at end of life. In the Panel's view however, it is not sufficient to simply not impede access. Given known issues with health literacy and challenges faced by some population groups, the Panel was clear that people should be provided with effective access to information. People from culturally and linguistically diverse backgrounds and others (for example those with low literacy levels or limited health literacy) may require additional help to access information in a manner they understand so that they can make informed choices.

Hon NICK GOIRAN: I will conclude on this point. I am troubled that the government made a deliberate decision to not include the provision that is in the Victorian legislation. I am disappointed that registered health practitioners in Western Australia are being treated differently from Victorian health practitioners. Registered health practitioners will be better off in Victoria than in Western Australia on the issue of conscientious objection. In that respect, I had the opportunity to read an explanation provided by a medical practitioner, for which I will give the source in a moment. He says —

Health care professionals who conscientiously object to professionally contested interventions may avoid participating in them directly, but, as with military conscientious objectors, who are required to perform alternative service, they cannot completely absent themselves from providing these services. Conscientious objection still requires conveying accurate information and providing timely referrals to ensure patients receive care.

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This individual goes on to say —

Health care professionals who are unwilling to accept these limits have two choices: select an area of medicine, such as radiology, that will not put them in situations that conflict with their personal morality or, if there is no such area, leave the profession.

I think that is what Hon Aaron Stonehouse has indicated is one of his concerns. As a result of this, we do not want to see health practitioners in Western Australia saying, “You have now radically changed medicine in Western Australia by virtue of what you are doing here. When I studied medicine for seven years at university and did all my internships and all the rest of it, I did not sign up for this. You have now radically changed this and now you are even making me have to provide information that goes against the grain of my ethics.” Notwithstanding that, in clause 4(1)(j) we have almost jokingly as a chamber passed a provision in the principles that says —

all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

I do not know why we bothered to pass that provision. I remain concerned. I said that I would indicate where the quote came from. It came from an article entitled “Physicians, Not Conscripts — Conscientious Objection in Health Care”, written by Dr Ezekiel Emanuel and Ronit Stahl in April 2017 and published in *The New England Journal of Medicine*. Although I do not propose to oppose the clause before us, I think it is a meaningless clause. I have a lot of sympathy for what Hon Aaron Stonehouse has just highlighted. I am concerned that we are forcing registered health practitioners in Western Australia to provide information on this subject. I hope they understand that that is exactly what we are doing.

Hon AARON STONEHOUSE: I thank Hon Nick Goiran for pointing out the fact that the principles of this bill are not worth much. We could essentially rip them out. The idea that all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics is not worth the paper it is written on. Neither is clause 9, really. It is all made irrelevant by the obligations in division 2. It is a tragedy. It is indicative of a type of advocacy, a sort of progressive mindset—apologies to some folks who identify as progressive; I do not mean to tar them all with this brush. There is a certain kind of mindset in progressive politics that mere tolerance is not sufficient. My view that I disagree with voluntary assisted dying, but I do not want to prohibit anybody else from accessing it, is not enough. No, people need to be enthusiastic about it. They need to be advocates too, and if they are not, what is the government going to do? It will give them a \$10 000 fine and strip them of their medical practice licence, or whatever other penalties the government can think up. It is not enough to merely be tolerant; it is not enough to live and let live. They have to be involved in this process intimately, with a gun to their head, essentially. What is the government going to do to people who cannot afford the \$10 000 fine—put them in a debtors’ prison? Ultimately, that is what we are talking about. We are talking about leveraging the coercive power of the state to force people into a position in which they are involved in a regime that they have a fundamental conscientious objection to and which goes against their moral fibre, and the government wants to force them into being part of this process. I think that is disgusting; I really do. Regarding doctors who do not want to take part in this process, there is not going to be any shortage of doctors who will provide VAD out there. I mean, honestly—as if everybody does not already know about VAD, with the largely publicised debate going on in this place about it. It is not enough for people to live and let live; mere tolerance is not enough. They have to be forced to do it. I am reminded of what has occurred in the United States, where people have been taken to the equivalent of the Australian Human Rights Commission for refusing to bake a cake. If they are Christian bakers and they refuse to bake a cake for a same-sex couple, they are hauled before these human rights commissions as a result. Mere tolerance is not enough.

Hon Alannah MacTiernan: Seriously, bakers in Australia have not had this problem.

Hon AARON STONEHOUSE: No, they have not, and I think that is good, although there was an instance of a photographer being subjected to the same treatment. Luckily, his case was resolved outside of the tribunal. The mere fact that he was hauled before a tribunal because he held certain views is ridiculous. I will be very concise because I know that I am getting a little off-track.

Surely, tolerance in this instance and a respect for each other’s rights and autonomy is the kind of debate that we should be having, rather than mandate an obligation to force people to take part in a regime of which they do not approve. I am a supporter of voluntary assisted dying in the sense that I want this bill to pass. Trying to protect the rights of one group of people, patients, to exercise bodily autonomy at the expense of another group of people, doctors, who have just as much right to exercise their autonomy to associate or disassociate with a regime of voluntary assisted dying is disgusting. We cannot correct injustice by punishing another group of people. It does not work that way.

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I do not oppose clause 9; I think it needs to be stronger. I also see the futility of the words in clause 9. I do not think they do anything. I will have more to say on this when we reach part 2.

Hon STEPHEN DAWSON: First of all, it is ludicrous to suggest that the bill is not worth the paper it is written on. I find that offensive.

Hon Nick Goiran: He didn't say that.

Hon STEPHEN DAWSON: That is what the member said.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Order!

Hon STEPHEN DAWSON: Whether it is the bill or the principle, I find that offensive. This is a very important bill for many Western Australians, and I am disappointed that the member does not agree with that.

We do not want to leave a patient who is dying and seeking medical information floundering in the community. Respecting someone's culture and religion does not mean that a person does not have to do their job. Approved information is about helping the patient. I am happy to bring to members' attention, as I did earlier today, the AMA's position statement on conscientious objection, specifically in relation to the provision of information. Part 2.3 of that statement states, in part —

A doctor with a conscientious objection, should:

- inform the patient of their objection, preferably in advance or as soon as practicable;
- inform the patient that they have the right to see another doctor and ensure the patient has sufficient information to enable them to exercise that right;
- take whatever steps are necessary to ensure the patient's access to care is not impeded;

As I have said, this is different from Victoria. We believe it is needed and necessary. I certainly support clause 9.

Hon ADELE FARINA: I want to put on the record that I agree with the views that have been expressed by Hon Nick Goiran and Hon Aaron Stonehouse. In my second reading contribution, I think I mentioned that I met with a doctor in Bunbury who is very disturbed about the fact that, despite very strongly held religious beliefs, he will be put in a position in which he needs to provide information on voluntary assisted dying to patients, even though he conscientiously objects. He told me that he would seriously have to consider closing his practice. That is how strongly he felt about it. I do not think we should undervalue the position in which we are placing a lot of doctors. A lot of doctors will struggle very much with this position. I agree with the views expressed by Hon Aaron Stonehouse that it is just not right. We cannot say that we have to respect one group of people's rights while we walk all over another group of people's rights. I agree that that is not an acceptable way to legislate, particularly when no harm is caused.

The other thing that I find particularly insulting is that we do not even know, as we are passing this bill, what information the doctors will be required to pass on to their patients. If it is simply the phone number of the navigator, that might be enough. Will they be required to refer them to another doctor who supports voluntary assisted dying? As legislators, we are supposed to be making informed decisions about exactly what this legislation will mean for the people it impacts. We stand here today about to pass this clause, which I agree has very little value, without even knowing what we are asking doctors to provide to their patients. I think that is pretty poor legislation.

Clause put and passed.

New clause 9A —

Hon MARTIN PRITCHARD: I move —

Page 10, after line 5 — To insert —

9A. Registered health practitioner not to initiate discussion about voluntary assisted dying

- (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person —
 - (a) initiate discussion with the person that is in substance about voluntary assisted dying; or
 - (b) in substance, suggest voluntary assisted dying to the person.
- (2) Nothing in subsection (1) prevents a registered health practitioner from providing information about voluntary assisted dying to a person at the person's request.

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This new clause is about empowering the patient to raise voluntary assisted dying if they choose and to then have a discussion with their doctor; it is not about getting involved in the relationship or discussions that they may have with their doctor. My belief is that voluntary assisted dying is not a treatment option—something that doctors have always discussed with their patients. It is an alternative choice that should be left up to the patient to raise. If there is a concern that the patient may not be aware of voluntary assisted dying, I say that there is broad support for the discussions that we are having. Many say that this bill has as much as 88 per cent support in the community. Even if some challenge that, few could say that this bill is sliding through this Parliament unnoticed. It is all over the newspapers every day that we have a discussion.

It would also be very unwise to rely on doctors raising this option, as many will choose not to—some because they have contracts or arrangements, some because of their personal beliefs, still more because they just do not want to get involved in the process and some because of where they work.

The department will have to develop many different strategies during the implementation stage to make sure that every person who is likely to face the challenges envisaged under this bill have the information to initiate the discussion with their doctor.

I support and have moved this new clause because of a lifetime of observing the outcome of discussions between two people trying to make a way forward for one of those participants. Granted, my personal experience has mainly been observing this between a manager and their employee, but I can see enough similarities to make me cautious. I have seen one dealing with this situation, confident in their knowledge and expertise, and the other feeling vulnerable and looking to the manager for guidance. I have seen the most empathetic manager be amazed that their employee came to me, as a union official, with concerns about the outcome of the discussions, and the manager often saying, “Why didn’t the employee raise it with me?” In reference to this bill, I am not saying that that will be the case all the time, but we are talking about a person who has just become aware that they may have as little as six months to live.

I note that the minister also has a new clause in his name and I appreciate the fact that he also has some concerns in this area, but I want members to understand that his new clause does not deal with the fundamental issue that I have, it does not deal with the fundamental issue that the honourable member for Armadale, Tony Buti, has and it does not deal with the fundamental issue that many people have who have raised it with me during the process of bringing this bill to Parliament. My new clause will empower the patient to raise the issue. It will be up to those who endeavour to implement this bill to deliver strategies that will make sure that people have the information so that they can raise this issue. That should be as far as it goes. It should empower the patient.

Sitting suspended from 1.00 to 2.00 pm

The DEPUTY CHAIR (Hon Martin Aldridge): Members, we are dealing with the Voluntary Assisted Dying Bill 2019. I draw members’ attention to supplementary notice paper 139, issue 9. We are dealing with an amendment standing in the name of Hon Martin Pritchard at 2/NC9A. The question is that the words to be inserted be inserted.

Hon MARTIN PRITCHARD: I had almost finished when we broke, but I will take this opportunity to re-emphasise a couple of points. The amendment I have put forward has been aired quite a lot. I have had many discussions with the member who moved the amendment originally in the other place. He is very supportive of me introducing it and trying to get it across the line here. The amendment is very specific; it is about empowering the patient to raise an alternative with their doctor and to have meaningful discussions with their doctor about treatment options and the alternative if the prognosis indicates that they are moving towards the end of their life. The amendment is about empowering the patient.

Considering the patient needs to have information, I raise this point again—that is, many doctors and medical practitioners in Western Australia will not raise this. I cannot guess how many, but there will be many. For instance, those who have a contractual arrangement with St John of God will be unlikely to raise this. Those who have a faith-based objection will not raise it. I include in that many doctors who —

The DEPUTY CHAIR: Order, members! It is not parliamentary to cross between the member on his feet and the Chair.

Hon MARTIN PRITCHARD: Many doctors will not do the training so they will not be in a position to have to take up this obligation. Other doctors will avail themselves of the training and, usually because of a specific patient, will get involved in the process. In my view, many doctors will not raise it with their patients. The Department of Health will be obliged to make sure that information is out there that will get to those people who live in faith-based facilities so that they have enough information to inquire if they so choose. People cannot just rely on the doctor having to raise it. If that is the case and as part of the implementation strategy the department has to make sure that people who could avail themselves of voluntary assisted dying have to have the information, why not empower the patient to raise it first? Why should we leave it to a situation whereby a patient is likely to be very vulnerable,

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having just received a prognosis of six months or less, or slightly longer in other circumstances? Why leave it to a situation whereby a very confident doctor may speak to a person very confidently, and the person who is feeling vulnerable may very well take that as advice that they should accept? If the department does its job and makes sure that every Western Australian is aware of voluntary assisted dying, what is the harm in empowering the patient to be able to raise it first? Do we think that the patient, knowing that it is available, will have some objection to raising it first? If they do, we are only emphasising that that person is concerned with the fact of having that discussion in the first place, and is vulnerable.

Hon Alannah MacTiernan interjected.

Hon MARTIN PRITCHARD: I am not taking interjections, thank you. The minister's bill deals with some of my concerns, but not my main concern—not the main aspect of my proposed new clause, which outlines who can initiate those discussions in the very private discussions between the doctor and the patient. If the patient is aware of what is available to them, why would they not raise it with their doctor in their very private discussions? The minister's proposed new clause does not deal with that specific issue.

I ask members to support my proposed new clause. It does not in any way, shape or form invalidate the bill. Whether members support the bill or not, I ask them to support my proposed new clause.

Hon STEPHEN DAWSON: Can I indicate—no surprises to Hon Martin Pritchard or others, given that I have a proposed new clause 9A on the supplementary notice paper—that the government does not support the member's proposed new clause, which would wholly prohibit a registered health practitioner from initiating a discussion about voluntary assisted dying with the patient. As we know and has been alluded to previously, Victoria has a prohibition, which was not supported by the Joint Select Committee on End of Life Choices or the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying. One reason for this is that there should not be an attempt to blanket censor the conversations that health practitioners have with patients. A medical or nurse practitioner should be able to raise and discuss voluntary assisted dying in the same way as other serious health or medical decisions and care options so that the patient is fully informed of decisions at the end of life.

Victoria is the only jurisdiction in the world that wholly prohibits health practitioners from starting a conversation about voluntary assisted dying. From the research of my advisers, we have found no other law that imposes a restriction on a doctor discussing with a patient a lawful treatment option that the doctor in his or her professional view believes is an option that the patient may wish to consider.

Preventing a medical practitioner from informing a patient about a legally valid option is an extraordinary measure that is fundamentally out of step with the basic principles of informed decision-making. It is fundamental to the proposed model for voluntary assisted dying in Western Australia that the patient's decision will be well informed. As with all other elements of health care, medical practitioners will make a reasoned judgement about whether it is appropriate to inform this patient at this time about their choice to consider requesting voluntary assisted dying. This is not about a medical practitioner suggesting voluntary assisted dying to a patient—it is about appropriately informing patients about their choices in a manner consistent with professional standards and in alignment with existing informed consent responsibilities. The bill has been drafted to enable appropriate access and provide essential safeguards. In order to allay concerns about a health practitioner coercing or inadvertently encouraging a patient to seek access to voluntary assisted dying, at least two medical practitioners—the coordinating and the consulting practitioners—must independently assess the patient. When an assessing medical practitioner is unable to determine whether the patient's condition meets the eligibility criteria—if they have decision-making capacity, or if their decision is voluntary and without coercion—they must refer for further assessment. Those provisions are under clauses 25 and 36. Furthermore, if they wish to proceed, the patient will be required to make a written declaration of their request to access voluntary assisted dying. That is at clause 41. This must be witnessed by two adults. If the person has completed a written declaration and makes a further final request, the coordinating practitioner must undertake a final review. In the final review, the coordinating practitioner must confirm that the process has been undertaken in accordance with the requirements of the legislation and that the patient has decision-making capacity in relation to voluntary assisted dying, that they are acting voluntarily and without coercion, and that their request is enduring.

Hon RICK MAZZA: I also have concerns, as raised by Hon Martin Pritchard, on this issue. When someone is diagnosed with a terminal disease, they would be in a fairly emotional state at that point in time. The relationship between doctor and patient can be quite an intimate one. I would imagine that many patients would hang on to every word from a medical practitioner. I do not think that voluntary assisted dying will be a secret. I think a patient will find out, whether through general knowledge or family members or friends, and at some point, someone will point out to them that this is an option available to them. I do not think that the medical practitioner necessarily has to instigate that discussion, particularly during those vulnerable moments. I will support the amendment put forward by Hon Martin Pritchard.

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Hon ALISON XAMON: I have given this matter quite a lot of thought because I have also been concerned about the power relationship, but from a different perspective. It occurs to me that much of the unwanted pressure on people to consider voluntary assisted dying, when they otherwise may not be inclined to do that, could come from the people immediately around them—family members, for example, and people who may mean well but should not be interfering. When we look at the concerns that have been raised by myself and others in this place around the possibility of elder abuse, with inheritance impatience, for example, we see concern about pressure coming to bear, particularly from people close to someone who may be living with a terminal illness. As such, I hope that it would be better that the information around voluntary assisted dying was first relayed to somebody through a medical practitioner who is bound by a code of ethics, and who is expected to conduct themselves in a particular way. Indeed, if that is then presented, somebody might be in a better position to get the full range of information that they require in a setting that will hopefully be more at arm's length than with a family member who may have something to personally gain by their death. I have reached the decision that I will not support the amendment as proposed, although I respect that it has been put forward in good faith. It is important that we acknowledge the potential for a power dynamic that may not be positive. I suppose, on balance, I am more concerned about an adverse power dynamic that may come from family members, as opposed to somebody who is bound by professional ethics.

Hon ALANNAH MacTIERNAN: I support the comments of Hon Alison Xamon and I rise to speak on this because I feel very strongly about this provision. Like Hon Alison Xamon, I know that Hon Martin Pritchard has brought this amendment forward in good faith, but I feel very strongly that it is absolutely the wrong way to go. The idea that we might be saying to a medical practitioner that they cannot tell the patient the truth—they cannot let the patient know the full suite of measures available to them—to me is personally repellent. The idea that we are legislating for the truth not to be told is horrific. To people, at a time of their life when they are going to be at their most vulnerable, and need to understand fully the options available to them, we are saying there is one option that is not allowed to be raised with them. People will be presuming that the doctor is telling them their options. He or she will be saying, "These are your options", but one is not being mentioned. The fact that one option is not being mentioned, even though they might have heard about voluntary assisted dying, might mean they think that they got that wrong, and it is not available. People need to know the truth. The idea that we would legislate to have critical information withheld from a patient at a time when they have to make one of the most important decisions in their life is truly reprehensible. The whole issue of power is that we would undermine the confidence of that person in believing that there is another option, that they might have heard about through this debate, because the doctor has not mentioned it to them.

Hon STEPHEN DAWSON: I will not delay the chamber for too long, but I want to make the point that it is important to acknowledge that the amendment that stands in my name proposing new clause 9A has been included following consultation with the Australian Medical Association's WA branch. I suggest that the amendment standing in my name reflects good clinical practice, and the current holistic context in which medical and nurse practitioners discuss medical options with a patient.

Hon TJORN SIBMA: I want to address the substance of the amendment moved by Hon Martin Pritchard, in a way that is sensitive to the integrity of that gentleman as a person of sound judgement in this chamber, because I absolutely understand the motivation behind the amendment. There is the matter of a power differential that is not insignificant. The context of the consultation is obviously one in which emotions are, significantly, almost immeasurable, coming immediately on the back of a diagnosis or prognosis. We cannot disregard that context. There are a few aspects to my challenge with supporting this amendment, even though I look favourably upon it. The first is the principle we establish by carving out an opportunity for state intervention into a consultation between a medical practitioner and the patient. I truly believe that the state does not belong there. It is problematic that it would be permissible to transmit some forms of information but not others, notwithstanding the precedent that this bill itself establishes. The second issue I have with the proposition is that I think it would be impossible to police. I attempt to adopt a pragmatic view of these issues. Frankly, there might not be a right or wrong moral answer, but the practicality of agreeing to this amendment causes innumerable problems. From that issue, a third problem emerges—that it would, in my view, create the opportunity for vexatious complaints to be levelled between practitioners, or between a family member and a practitioner, that could not be upheld or proven, but that would come at a detriment to the reputation of a general practitioner or any other medical profession engaged in this process. I want to underscore the fact that I think this amendment comes from a very sound moral place. I think Hon Martin Pritchard is a person of great integrity and would not flippantly move an amendment just for the sake of it. I encourage people to treat it with some seriousness; but they are my problems with supporting the amendment as the member has put it.

Hon JACQUI BOYDELL: I also agree that Hon Martin Pritchard has given a lot of consideration to this amendment. The fact that he moved the amendment has allowed the house to have this rather in-depth discussion. It has been a cause for concern of many members of the public, and people have raised this issue with me. They feel sensitive about it, and, rightly so, we should have the discussion.

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I think the premise of the amendment comes from a place of wanting to protect the vulnerable, particularly people who may not have support mechanisms around them and who rely on the relationship with their medical practitioner more heavily than do some others and, therefore, comes that mismatch of power in the relationship between doctor and patient. However, I cannot support the motion, because of some of the other ideals put today, particularly by Hon Alison Xamon and Hon Alannah MacTiernan. As a patient, I want the right to have an honest discussion with my medical practitioner and allow them to give me the information and therefore the choice. That is probably my fundamental reasoning for not supporting the amendment. I do not think I want to be in a situation in which medical practitioners are not able to give information to patients because the legislation says they cannot, when they can clearly see that patients may need some of their advice. We have to rely on the medical practitioners within the medical profession to give advice, as they do every day. We have faith in and we trust that system. I absolutely agree that checks and balances have to be in place. However, it comes down to the patient making the choice. That is probably my reasoning. The process after that still has to be followed. The coercion and power base is still tested because the process still has to be followed.

The other thing I think the member talked about when moving his amendment was that during this debate, voluntary assisted dying has been something the community knows about. That might be the case at the moment, but it might not be the case into the future. Although it has a lot of media attention and a lot of people are talking about it currently, that might not be the case in 20 years. There has to be a touch point at which people know that they can get some free, frank and honest advice and then have a process that will allow them to make the decision. That is why I cannot support the amendment put today, but I thank the member for bringing the amendment to the house.

Hon SIMON O'BRIEN: This is a very interesting point that we are discussing. I want to join other speakers in acknowledging what I am sure are the purest of motives all round. When it all boils down, one thing we have in common, I hope, is that, firstly, we are all in the people business. We are politicians; we are elected representatives. Not only that, we are also sons and daughters and mums and dads. We are people ourselves and we are motivated in part to be here because we are concerned about the welfare, in every respect, of all our people and generations to come. That is one humanising aspect that is coming through as we contemplate the honourable member's proposed amendment here and the motives that I am sure lie behind it. It is in those respectful terms that I want to offer the following comments. Firstly, some people might be thinking, given that I am strongly opposed to the principle behind this bill, that I would embrace the sentiments in this amendment—on the contrary, I do not. Again, I am in the business of being not only a person, but also a legislator, and I do not think that this will work. I think, like Hon Tjorn Sibma, that it creates problems rather than fixes them. I do not think it is necessary at all and, indeed, could well be counterproductive. I will briefly explain why. In the course of contemplating our approach to this bill, we have had the benefit of advice from a range of people. We all have our own life experience, and a number of us have shared some little parts of that in ways that are relevant to the issues that we are talking about. We all have that essential human life experience, but we have been further reinforced in that by the advice of professionals in all these health fields. We have had palliative care experts available to us, people from Charlie's, the Australian Medical Association, in all its various stripes, and a range of other affected, interested parties, not the least of which being a whole lot of well-motivated people in the public who were either strongly for or against the measures that are proposed in the bill, and all the rest of it.

We have learnt from all the professional, expert advice—the people who are dealing with patients and are in the extreme situation that is contemplated by this bill—and we have learnt from those who are near end of life and are suffering from severe pain and distress and are unable to find relief. Mercifully, that is a very small percentage of people. When we talk to professionals who are involved with those people, we hear about the sorts of things that are not remedied by this proposed amendment. I hope that the respectful tone of my remarks just now, when they are printed in black and white on the page, show everyone that what I am about to say is in no way intended to be flippant. I want to make things work for people. That has been my whole history in this place. I want to make things a bit easier for my community in going about their lives.

What happens, as has been discussed here, when someone receives a terminal diagnosis, which I think one member referred to as “bad news”? What is the reaction that we get? We have heard all about this. The immediate reactions are, perhaps, shock, disbelief, a sense of uncertainty and a search for further answers. In not one example have I heard advice that a typical reaction of a patient in that situation is, “Oh, heck! That sounds dreadful! I'd better speed up the process by accessing an early demise.” Again, I am not being flippant when I say this, but that is not what people say. Yes, people will be distressed, people will get a shock, people will perhaps panic and not know what to do, but I do not think that they will start reaching for the Voluntary Assisted Dying Act 2019 as their first avenue of recourse.

Similarly, I do not imagine for a minute—it has been suggested that this scenario might be real, but I ask members to just think about it—that a doctor providing a terminal diagnosis to their patient is in the next breath going to say, “I can see you're shocked, but don't worry. It's all right because you've now got access to voluntary assisted

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dying.” That is not the sort of situation that any of us could seriously contemplate happening. It is not something that needs to be addressed. I also agree with Hon Tjorn Sibma when he strongly put the case of whether we, as legislators, should really be diving so deeply into what a patient and their health professional can talk about and how they are meant to talk about it. No, of course we should not. Perhaps we ought to back off from that for a minute and consider what is actually being proposed.

I am going to draw my remarks to a close very shortly, but the final aspect I ask members to contemplate is how it will work in practice. I have had a number of jobs prior to coming into this place in which I was involved in a practical way in compliance, law enforcement and so on. I have contemplated lots of sets of acts and regulations of all sorts, some with provisions that work and others that were written by people who perhaps did not quite understand what works in practice. We want to produce legislation here that exhibits the attributes of the former rather than the latter. This amendment would provide an extra section in the proposed act. I think that would impose an impediment. I cannot see how it would ever be applied in real life. We are not going to stop doctors and patients from having discussions and no practitioner is going to come forward and say, “Yes, the first thing I did was to initiate a discussion with my patient recommending voluntary assisted dying.” It is not going to happen. It is never going to happen. There will be disputes. Maybe other relatives will say, “I reckon that doctor raised this subject”, but where will that leave us? The doctor will say, “No, I didn’t. My patient was asking whether this was something they would have to do, so I was talking them through it.” That is the reality. Why do we need black-and-white law that will facilitate a problem? With the greatest respect—the honourable member knows I respect him greatly—I would not put this amendment aside unless I had those reservations I have expressed that are held very deeply but also very practically. I do not offer that in the sense that I think the honourable member’s idea is wrong; I praise the member for his motivation, but I suggest, with respect, that the proposed act would be better if it were silent on this matter.

Contemplating the last aspect is an amendment in the minister’s name on behalf of the government. I might ask members for a little a courtesy in a moment to conclude these remarks. Again, I say with respect that this is an endeavour by the government to address something that, as I have just discussed, is a misrepresented problem. The government’s new clause 9A on the supplementary notice paper does nothing more than to add a whole page of legislation that we really do not need.

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Simon O’Brien.

Hon SIMON O’BRIEN: I thank members for their courtesy. In conclusion, not to finish on a negative note, I say that because—I think I am offering some support for the minister in doing this—the new clause that is contemplated goes well until the end of new subclause (2). However, new subclause (3) says that they can talk about it and they can raise the issue, but only so long as they do it in the context of a general discussion that raises a whole lot of things. I think it is better—again, I go back to my colleague Hon Tjorn Sibma’s remarks—not to intrude with this sort of specificity on what a doctor and a patient can and cannot talk about within their own private counsel. It might surprise members that I am not supporting this amendment, but it is for those reasons that I am not. Once we adopt the policy of what is contained in this bill, it is at that point that that particular genie is out of the bottle. I have indicated what I think about that, and there will be another vote in due course about that. The thing is, once we let the genie out of the bottle we then have to manage it, but if we start trying all these other extra methods to half-heartedly shove it back in the bottle while still letting it run around, it will only create more problems. My respectful advice to the chamber is: do not let the genie out of the bottle in the first place, but that is a debate for a later stage. I am sorry that I cannot support this amendment.

Hon AARON STONEHOUSE: It is interesting to hear members talk about their reluctance for the state to interfere with the discussions doctors have with their patients. I share that sentiment somewhat, and I look forward to receiving the support of members for my amendment, which seeks to remove the obligations on medical practitioners to provide information to patients who request it. I think that is precisely the same thing we are discussing here. I thank Hon Martin Pritchard for moving this amendment. It addresses a concern that I have raised outside this place and in my contribution to the second reading debate about a problem that I think exists and that I think most people would agree exists, and that is the power imbalance between a patient and a medical practitioner. The question is not whether that power imbalance exists; it is what to do about it. How do we address that power imbalance, and is this amendment the appropriate way to do so, or are there other mechanisms? I am not yet entirely sure. There are questions about how this might be implemented and how it might be enforced. There are also questions about whether it goes too far. I am keen to hear whether there are other ways of addressing the problem, how this amendment compares with the amendment that the minister has on the supplementary notice paper, and whether that amendment might go further in addressing this problem in, perhaps, a less onerous way. It might be in a more onerous way, as has been suggested; it might create its own problems.

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To begin with, I would like to ask a couple of questions just for some clarification on an aspect of this amendment. This is a question that the mover of the amendment might be able to answer, or it might be answered by the minister, with the help of his advisers. If this amendment were to be agreed to, would it prohibit medical practitioners from having in their practices material—brochures, pamphlets, posters and what-have-you—that communicates voluntary assisted dying? This amendment takes its wording from the Victorian legislation, and during debate in the Victorian Parliament on its legislation, the responsible minister claimed that it would prohibit the display of material, including pamphlets, brochures and so on. Would the same thing happen here in Western Australia if this amendment were to be agreed to?

Hon MARTIN PRITCHARD: I would envisage not. That may not be a legal response, but I would envisage not.

Hon STEPHEN DAWSON: I think Hon Martin Pritchard has answered the member's question—no. If the material were on a counter or on a wall somewhere, no; this amendment would not preclude that.

Hon AARON STONEHOUSE: That is interesting, because it was said in the Victorian debate that it would prohibit people carrying that material; at least that is what is in *Hansard*. I do not have an easily accessible copy of it to provide to the minister or to Hon Martin Pritchard, but I am a little confused as to whether that is the case. It was also asked whether a medical practitioner could advertise on their practice website that they provide voluntary assisted dying services. Forgetting for a moment how that would work with the commonwealth Criminal Code Act—we will put that aside for the time being—there is a question about whether that would be in contravention of the prohibition on medical practitioners initiating discussions about voluntary assisted dying. If a practitioner had on their practice website, “Stop in at Dr Smith's practice for VAD”, would that be in contravention of this provision?

Hon MARTIN PRITCHARD: If you are asking me—again, this may be not the legal response to this—I would say it does, if it was on their website, but of course that would be in contravention of the federal legislation. That is because it is initiating a discussion. The crucial point in the amendment that I have moved is that a doctor is not to initiate the discussion. Initiating a discussion does not necessarily have to be verbal, in my view.

Hon NICK GOIRAN: If members take a moment to study the experience in the few jurisdictions around the world that have legalised a form of VAD, whether that be voluntary euthanasia or physician assisted suicide or however the regime is described in that jurisdiction, they will know one thing—steering is the elephant in the room. The originating author of the particular provision moved by Hon Martin Pritchard is, of course, as he has attested to, the member for Armadale. This amendment will prevent steering by doctors. As Hon Alison Xamon quite rightly identified earlier, it will not prevent steering by family members. I share her concern that once this regime comes into place, inevitably, and sadly, some family members are going to steer their family member down this particular path. I am saddened by that, but I cannot do anything about that, because, as Hon Simon O'Brien has said, if we do not want that to happen, do not allow the genie out of the bottle in the first place. But what I can do, members, is support Hon Martin Pritchard, who is at least trying to ensure that there is no steering by medical practitioners in Western Australia.

I want to correct the record for something that the Minister for Regional Development said. The minister suggested, in good faith, that somehow this amendment will not allow doctors to tell the truth to their patient. I draw to members' attention proposed new clause 9A(2) moved by Hon Martin Pritchard. That specifically states —

Nothing in subsection (1) prevents a registered health practitioner from providing information about voluntary assisted dying to a person at the person's request.

Nothing in this amendment will prevent a doctor from providing truthful information.

Hon Alannah MacTiernan: It does. The person is asking for the full range of options, and legally the doctor is prevented from raising one of those options. If the person says, “But what about this other option I've heard about?”, truly, you are right, but if the person does not ask that question, they will not know. My point is that when a doctor is purporting to set out the range of options and does not include that one, many people will think, “I must have this wrong. It must not be available to me.”

Hon NICK GOIRAN: What I was about to say —

Several members interjected.

The DEPUTY CHAIR: Order, members! Hon Nick Goiran has the call.

Hon NICK GOIRAN: Let me just indicate that, as always, I have absolutely no problem with any robust debate, and I welcome it. I reiterate that I take the remarks made by the Minister for Regional Development in good faith. I am just trying to explain why I do not agree with what has been said. I do not see that there is anything in new clause 9A proposed by Hon Martin Pritchard that would prohibit a doctor from telling the truth to their patient.

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That is not what new clause 9A will do. I note, whilst we are talking about the issue of truth and how important that is, that I look forward in due course to getting to clause 81(6), which states, as members might be aware —

The medical practitioner must not include any reference to voluntary assisted dying in the cause of death certificate for the person.

It states that they “must not”. In other words, they must not tell the truth on the death certificate. But we will address that in due course. I emphasise to members that proposed new clause 9A(2), as moved by Hon Martin Pritchard, will allow and absolutely encourage truth-telling by practitioners to patients; the issue is who starts the conversation. Does the doctor steer the patient down this particular path or does the patient say to the doctor, “I would like to consider this as an option. Tell me what the situation is?” It is about who initiates the discussion; that is all. As soon as the patient initiates it, a practitioner, if they want to provide that information, will provide the information in accordance with the act.

I have to say that what persuaded me to support this amendment was clearly the rigorous work undertaken by the member for Armadale in the other place. I want to draw to the attention of members some of the things that the member for Armadale said in the other place. He quoted extensively from the Victorian “Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report”. He said this —

... I will read what it says at page 91. It states —

In 2016, a Victorian Parliamentary Committee Inquiry into abuse in disability services identified widespread abuse and neglect of people with a disability in disability services in Victoria. Concerns about a lack of respect for people with a disability or different treatment of people with a disability were also raised during consultations. The Panel recognised the importance of addressing these concerns when considering its recommendations.

The Panel supports the Government’s ‘zero tolerance of abuse of people with a disability’ and notes the measures taken by the Government in response to the Inquiry, including strengthening oversight of disability services. This includes the creation of a new code of conduct for disability workers and greater support and training to identify and respond to abuse of people with a disability. Recent steps to clarify the roles of Victoria Police and the Disability Services Commissioner will also assist in responding to instances of abuse effectively.

He then said —

The report continues —

The framework recommended by the Panel does not allow people to make judgments about the lives of others. The framework allows people who are already at the end of their life to make a choice about how they will die. This decision must always be made by the person themselves. The Panel is confident that the process recommended will identify any coercion or undue influence, and ensure that this is dealt with appropriately.

Ministerial advisory panel Recommendation 7

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

The member for Armadale then went on to say —

Then I come to recommendation 8 of the Victorian ministerial advisory panel, which is the one that I am seeking to follow. It states —

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Policy intent

To ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person’s own voluntary decision.

For the benefit of *Hansard*, that is found at page 6479 of the Legislative Assembly *Hansard* on 4 September 2019. All those remarks were made by the member for Armadale, who is the original author of the matter that is currently before us, which, thankfully, has been brought to our attention by Hon Martin Pritchard.

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I note that recommendation 8 of the Victorian ministerial expert panel accords with the warnings issued by the late disability activist Stella Young, who made it very clear that social attitudes toward people with a disability come from a medical profession that takes a deficit view of disability. On 18 October 2013, in an article entitled “Disability—a fate worse than death”, she had this to say —

As a disabled person, I’m accustomed to conversations about quality of life and dignity. Specifically, I’m accustomed to assuring people that my life is worth living. I’m short statured, a wheelchair user, and I frequently have bone fractures. All the visual cues that make me ‘the other’ are front and centre. People make all sorts of assumptions about the quality of my life and my levels of independence. They’re almost always wrong.

I’ve lost count of the number of times I’ve been told, “I just don’t think I could live like you,” or “I wouldn’t have the courage in your situation,” or, my favourite one to overhear (and I’ve overheard it more than once), “You’d just bloody top yourself, wouldn’t you?”

What we as a society think we know about what it means to live as a disabled person comes from cultural representations of disability seen through a non-disabled lens. And we, as people with disability, rarely get to tell our own stories.

Also, social attitudes towards disabled people come from a medical profession that takes a deficit view of disability.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: The article continues —

This is my major concern with legalising assisted death; that it will give doctors more control over our lives.

As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I’ve experienced some of the very worst disability prejudice and discrimination. Doctors might know about our biology, but it doesn’t mean they know about our lives.

That is a quote from Stella Young in an article under the heading “Disability—a fate worse than death?” on the ABC’s Ramp Up webpage on 18 October 2013. In my minority report from the 12-month inquiry, I referred to the legalisation of voluntary assisted dying, which is being pushed by the government at this time, as taking place —

... ‘within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities.’ Already, this prejudice and discrimination play out in life-threatening ways, including pressure by hospital staff on people with disabilities who are nowhere near death to sign ‘Do Not Resuscitate’ orders and reject life-sustaining treatment.

The Joint Select Committee on End of Life Choices received evidence on the inequitable access to health care that people living with disabilities in Western Australia already face. In the absence of a prohibition against doctors raising voluntary assisted dying with a patient, the introduction of this voluntary assisted dying legislation is, in my view, a recipe for disability discrimination, and the outcomes will be fatal.

When the member for Armadale was prosecuting the case for this amendment, he referred to the presumption of undue influence. This is what he had to say on 4 September 2019 at page 6480 of *Hansard* —

My drive for this prohibition is not just for people with disabilities; it could also be for older people or anyone, in fact, because it is understood under law that there is a presumed undue-influence relationship between a doctor and a patient. That is one of the presumed relationships of undue influence. We do not have to prove actual undue influence; we start off from a presumption of undue influence.

The responses that I have received since I wrote my op-ed are interesting. Some people approached me and asked why I want to do this, because I will be affecting people’s ability to access VAD or I will prevent a doctor from giving all the clinical options. That may be so, but what about the protection of the vulnerable? Surely that is also very important.

The Leader of the Liberal Party, Hon Liza Harvey, also raised concerns about the impact of practitioners being able to raise voluntary assisted dying with their elderly patients. This is what she had to say on that same day —

I rise to support this new clause. I had a similar amendment drafted, but the member for Armadale pipped me at the post in putting it on the notice paper. I concur with everything he has so eloquently put about protections for vulnerable people. He talked about people with disabilities, who are one category of vulnerable people. The other category of vulnerable people I am particularly concerned about is our seniors and the elderly. I know from dealing with elderly people in my constituency and also elderly grandparents who are sadly no longer with us that they absolutely revere the medical profession and will do whatever medical practitioners tell them.

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She went on to say —

That choice will be influenced by somebody else whom they trust, somebody whom they hold on a pedestal and think is smarter than them, knows more than them, has more experience than them and understands what is best for them. For those individuals, we cannot take the risk. This amendment has a precedent because it is in the Victorian legislation. I do not believe that it will fundamentally affect access to voluntary assisted dying for the people who want to access it for the various reasons that they do. I think it will be a small number of people. But even if one vulnerable person is talked into voluntary assisted dying after a doctor initiates that conversation, we in this place will have failed. If members think about the conversations about the death penalty, they are all predicated on the one innocent person who was put to death and subsequently found to be not guilty. We need to view this legislation and this amendment through the prism of the one individual, the one vulnerable person who may be influenced by a doctor, even if that doctor thinks that they are doing the best thing for their patient.

I note that consideration of presumption of undue influence is not found anywhere in the final report of the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying.

Dr Buti, the member for Armadale, also made reference to concerns raised with the final report of the WA ministerial expert panel, having heard mixed views about doctors initiating the discussion. On page 30 of the WA ministerial expert panel report, this remark was made —

Discussions that took place in the Kimberley raised issues in relation to self-harm and suicide and noted that even discussing palliative care with patients can be challenging in this context. There may be complexities surrounding concepts such as blame or ‘pay back’ in Aboriginal communities and potential implications if the family has a negative perception of the practitioner or health service because of involvement in voluntary assisted dying.

I refer to a quote from the Kimberley Palliative Care Service at a consultation stakeholder meeting, which states —

‘High turnover of staff and GPs is a huge issue. For people to establish a relationship with their GP to even have a discussion about voluntary assisted dying is hard’.

The Western Australian ministerial expert panel report continues by saying —

The complexity of medical terminology and the balance of power between health practitioner and patient was also identified as potentially challenging and would require thorough consideration during any implementation planning (including being part of practitioner education and training).

To that I say that we are not leaving it to the implementation phase, we are dealing with it now, because this is what has been brought forward to us by Hon Martin Pritchard.

In the ministerial expert panel’s final report, there is also an excerpt from a submission by the Aboriginal Health Council of Western Australia, which states —

‘Clinicians often use complex medical terminology when discussing treatment options with Aboriginal people ... This results in the real risk that Aboriginal people may consent to something they don’t fully understand.’

I pause there to say that they are not my words; they are the words of the Aboriginal Health Council of Western Australia to the ministerial expert panel. I take the health council at its word when it goes on to say —

‘There is also the issue of the disparity of power between a doctor and Aboriginal people; Aboriginal people will often agree with a doctor’s advice even if they are not happy with it as they can feel overpowered in the doctor–patient relationship’.

Despite those concerns, in its conclusion on page 31 of the report, the ministerial expert panel said on this issue —

The Panel carefully weighed the outcomes of the consultation and knowledge of other jurisdictions, with the unique cultural circumstances of Western Australia in its deliberations on this matter.

The Panel believes that health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying.

The Panel acknowledges the position of the Joint Select Committee and agrees that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with patients, including that there be no prohibition on health practitioners appropriately raising the subject of voluntary assisted dying.

With all due respect to the ministerial expert panel, it reached this conclusion in its final report without any reference to the presumption of undue influence between doctors and their patients, as drawn to our attention by the member for Armadale. Perhaps he should have been a member of the ministerial expert panel. In contrast with the

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recommendation made by the Victorian ministerial expert panel, as quoted by the member for Armadale in the other place, the WA ministerial expert panel's final report contains this recommendation. Recommendation 6 states —

Health practitioners are able to appropriately raise the topic of voluntary assisted dying with a patient.

Policy intent: *To ensure that people are able to make fully informed decisions at end of life. To ensure that access to voluntary assisted dying is not impeded by a health practitioner not discussing what would be a legal option at end of life for some people.*

I am about to conclude my remarks on this issue by referring to an article that appeared in *The Australian* of 10 October this year. It states —

Australia's first indigenous surgeon, Kelvin Kong, says he is terrified by the McGowan government's plan to let doctors suggest voluntary assisted dying, describing patients in remote areas as often so thankful to see a specialist that they are "very compliant".

The CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: That surgeon goes on to say in that article in *The Australian* —

Our medical training is really good at teaching us about disease, but it's not really good at teaching us an understanding of cultural complexities, particularly with our most disenfranchised people."

Professor Kong said his urban patients, including indigenous urban patients, were generally confident about their ability to make an informed decision but in rural and remote Australia he met patients who were just thankful to finally see a specialist.

Farmers and indigenous people were among regional patients who were vulnerable.

I fully support the amendment that has been moved by Hon Martin Pritchard. If nothing else, I acknowledge his courage in putting forward the amendment, which I believe will go some way, but cannot entirely, as Hon Alison Xamon quite rightly identified, towards protecting vulnerable members of our WA community, including people living in regional and remote areas, Aboriginal people, the elderly and people living with disabilities, from undue influence and reinforces the voluntary nature of an assisted dying request. For those reasons, I indicate my support for the motion moved by the honourable member.

Hon STEPHEN DAWSON: I return to the interchange between Hon Alannah MacTiernan and Hon Nick Goiran earlier about Hon Martin Pritchard's proposed new clause 9A(2). That allows a medical practitioner to tell the truth but only if asked to do so and not otherwise. I wanted to make that point. That is how I read that new clause.

I wanted to raise a couple of other issues. The ministerial expert panel served to represent the views of the whole of the Western Australian community. This included people with disability, disability advocacy groups and individuals with disability. Views expressed on whether a medical practitioner could raise the subject of voluntary assisted dying were mixed. People with Disabilities (WA) and the Australian Federation of Disability Organisations stated when giving evidence to the joint select committee that there is no evidence to suggest from either the Oregon or the Netherlands data that people with disabilities are at heightened risk of assisted dying. Vulnerable groups generally, including women, ethnic minorities, people from lower socioeconomic circumstances, children and people with a psychiatric disability or dementia, were not found to be at any heightened risk of assisted dying. Evidence from both Oregon and the Netherlands demonstrates that members of vulnerable communities are no more likely to receive assistance in dying and that the demographic profile of a person accessing voluntary assisted dying was typically someone with comparative social, economic, educational and professional advantage.

There are obviously people with disability who do not support the legislation before us, as there are people with disability who are supportive of the legislation. Ms Samantha Jenkinson, the executive director of People with Disabilities (WA), was part of the ministerial panel, and she is supportive of the panel's recommendations. We also heard from Hon Nick Goiran that an Aboriginal surgeon is not supportive of the legislation. Aboriginal people are also involved in the process and we had an Aboriginal person on the ministerial expert panel. The reality is that there are Aboriginal people who are for and against, there are people with disabilities who are for and against, there are members of Parliament in this place who are for and against and there are people in the general community who are for and against. Where the government has landed with the new clause that stands in my name has come after taking into consideration the views expressed by a number of people about, and the issue raised in, Hon Martin Pritchard's new clause. As I said previously, the new clause standing in my name is there after consultation with the Western Australian branch of the Australian Medical Association. Again, I reiterate that we are not supportive of the new clause that stands in Hon Martin Pritchard's name.

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Hon MARTIN PRITCHARD: I would just like to thank everyone for their input on this. I will continue to support my new clause, but I understand that people are landing in a different spot after consideration. I fully respect the fact that they have considered the new clause.

Hon AARON STONEHOUSE: The minister has just mentioned his new clause on the supplementary notice paper. It seems to address some of the same concerns that members in the chamber are feeling about the risk of undue influence and the power imbalance between a patient and a medical practitioner, but it is hard to consider the question before us now without knowing how it compares somewhat with the new clause that the minister will put forward. It seems that the aim of the minister's new clause is to ensure that if a medical practitioner raises the issue of voluntary assisted dying —

Hon Stephen Dawson: Honourable member, would you like me to —

Hon AARON STONEHOUSE: That might be helpful, yes, if it is not out of order to do so. We are faced with three options: Hon Martin Pritchard's new clause, the minister's new clause or doing nothing and leaving the status quo and the bill as it is. I think it would be helpful to understand not only how the government's new clause would operate in contrast with the new clause put forward by Hon Martin Pritchard, but also perhaps some of the rationale behind it. Is it the same risk that has been identified by Hon Martin Pritchard and many others that the government is trying to mitigate or is it something else? What is the rationale behind the government's new clause?

Hon STEPHEN DAWSON: The proposal by the government introduces a new prohibition that a healthcare worker must not initiate discussion with a person that is in substance about voluntary assisted dying or in substance suggests voluntary assisted dying to the person in the course of providing health services or professional care services to the person. An exception would apply, though, to a medical practitioner or nurse practitioner in that they may initiate the discussion with a person when they, at the same time, also inform the patient about all their treatment and care options, including palliative care and treatment options.

As I have said, this proposed clause has been included following consultation with the AMA. I am advised that it reflects good clinical practice and the current holistic context in which medical practitioners and nurse practitioners discuss medical options with patients. The government considers this to be a good provision as it addresses concerns raised in the other place about patients who are prone to adopting another person's opinion or view even when that view may be a mere suggestion rather than anything amounting to coercion. The new clause seeks to balance a person's right to be informed of all medical options available with the protection of those who are more vulnerable. A breach of this provision would result in sanctions under the Health Practitioner Regulation National Law (WA) Act for registered health practitioners for unprofessional conduct. In the case of a healthcare worker who is not a registered health practitioner, they would fall under the definition of "provider" in the Health and Disability Services (Complaints) Act 1995 and thus be subject to the provisions on unreasonable conduct for the purposes of that act.

In short, the new clause in my name has come about as a result of listening to some of the concerns raised in the other place, talking to the WA branch of the AMA and balancing the issues. We think that where we have landed is the right balance.

Hon AARON STONEHOUSE: At a glance, it seems to be far more balanced, although I note that if a patient initiates the conversation, there is no obligation in this new clause for the medical practitioner to provide information about palliative care. That obligation exists only if the medical practitioner initiates the conversation about voluntary assisted dying. That is something that we can discuss in more detail when we get to consideration of the minister's new clause, if we get there.

It is also worth noting that although it creates or at least confirms that it is a contravention of aspects of this act for a medical practitioner or a registered health practitioner—a health practitioner, in looser terms, such as used in the principles of the bill, and that could be someone such as a social worker—there is no prohibition on them discussing or raising voluntary assisted dying with a patient. That is not necessarily a bad thing. I think it would be impractical to say that nobody can initiate a conversation about voluntary assisted dying. That would be almost impossible to enforce and would be a bit ridiculous. It would prevent families from having frank and open discussions about voluntary assisted dying. They are a couple of observations about it.

During the debate in Victoria, a concern was raised by a palliative care physician about a similar clause. He or she raised the concern that being prohibited from raising voluntary assisted dying as an option with a patient might put them in breach of their obligation to provide care to a patient—it may be a breach of their duty of care to a patient to raise treatment or other options with their patient. At the time it was claimed by the responsible minister that having a prohibition on initiating such conversations would not put them in breach of their duty of care as nothing would prohibit them from discussing VAD if the patient raised it in the first instance. I wonder whether the minister or the mover of the motion has anything to add to that. If there is a prohibition on a medical practitioner raising voluntary

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assisted dying, could that be seen as in some way interfering with their ability to carry out their duty-of-care obligations to their patient? Let us say they are in a palliative care setting. They would be able to talk about different palliative care options, such as terminal sedation, but they would be prohibited from raising the option of VAD with a patient. Does the member see that as a violation of their obligation to provide a duty of care? Does it raise any ethical issues in the member's mind, or does he think the risk is too great, so it is better to put the prohibition in place in the first instance? Does the member have anything to add on that? It is something that I noticed was raised as an issue in the debate in Victoria when they discussed a similar clause.

Hon STEPHEN DAWSON: Returning to my amendment for a second, I want to draw the member's attention to something. In my amendment we use the words "health care worker", which is broader than "registered health practitioner". This widening is to address concerns that have been raised that those people who provide health services to a patient may influence a patient to act in a manner other than they ordinarily would. "Health care worker" does include social worker and Aboriginal health worker. I just wanted to make that point.

Hon AARON STONEHOUSE: Under the minister's new clause 9A(1)(b), "any other person who provides health services or professional care services" could be interpreted pretty broadly, I suppose.

Hon Stephen Dawson: Absolutely.

Hon AARON STONEHOUSE: That would include perhaps a social worker or Aboriginal care worker or something along those lines; okay.

Hon MARTIN PRITCHARD: Just briefly, if I may: it does not raise any concerns in my mind, mainly because I do not believe that voluntary assisted dying is a treatment option; I think it is an alternative choice.

The CHAIR: Members, we are contemplating the proposed new clause moved by Hon Martin Pritchard. I am about to put the question, but we need to clarify that. I also clarify that I think it is quite proper that we have allowed the Committee of the Whole to contemplate an alternative amendment that deals with substantively the same issues. However, if and when we get to that in due course, I hope that members will concede that a large part of that debate has been had. I do not want it to get repetitive.

Division

New clause put and a division taken, the Chair casting his vote with the noes, with the following result —

Ayes (9)

Hon Donna Faragher	Hon Rick Mazza	Hon Aaron Stonehouse
Hon Adele Farina	Hon Martin Pritchard	Hon Colin Tincknell
Hon Nick Goiran	Hon Charles Smith	Hon Ken Baston (<i>Teller</i>)

Noes (23)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Matthew Swinbourn
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Robin Chapple	Hon Sue Ellery	Hon Michael Mischin	Hon Darren West
Hon Tim Clifford	Hon Diane Evers	Hon Simon O'Brien	Hon Alison Xamon
Hon Alanna Clohesy	Hon Laurie Graham	Hon Samantha Rowe	Hon Pierre Yang (<i>Teller</i>)
Hon Peter Collier	Hon Colin Holt	Hon Tjorn Sibma	

New clause thus negatived.

The CHAIR: We now move to contemplate new clause 9A, as shown on the supplementary notice paper at 458/NC9A. I have not forgotten the other one standing in Hon Charles Smith's name, and we will come back to that, but, for now, because we have already canvassed this proposed new clause, unless there is violent objection, we will go directly to that one.

Hon NICK GOIRAN: I just want to confirm that this will not create any problem with moving 30/NC9A in the name of Hon Charles Smith. The context in which I ask that question is what I understand was a ruling, an expression or a direction earlier in our debate, that it would be necessary for us to continue on the supplementary notice paper in the order that is before us, and that, when we want to vary that, there would have to be some other mechanism to go back. I am, perhaps like you, Mr Chairman, very relaxed about this; I think that is the expression you used. I am relaxed as well. I just want to make sure that we are not creating any issue for Hon Charles Smith.

The CHAIR: Member, please be reassured that it is all under control. The point you make is valid to the extent that we do not go backwards on a supplementary notice paper, but we are at exactly the same point, which is a proposed new clause 9A, as it was just a moment ago. Indeed, once we have disposed of this matter, we might have a new

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clause 9A, in which case we will contemplate Hon Charles Smith's proposed new clause 9B, I think, which is moving in the right direction. Hopefully, your Chairman has saved the day yet again, Hon Nick Goiran! You can relax.

New clause 9A —

Hon STEPHEN DAWSON: I move —

Page 10, after line 5 — To insert —

9A. Health care worker not to initiate discussion about voluntary assisted dying

(1) In this section —

health care worker means —

- (a) a registered health practitioner; or
 - (b) any other person who provides health services or professional care services.
- (2) A health care worker who provides health services or professional care services to a person must not, in the course of providing the services to the person —
- (a) initiate discussion with the person that is in substance about voluntary assisted dying; or
 - (b) in substance, suggest voluntary assisted dying to the person.
- (3) Nothing in subsection (2) prevents a medical practitioner or nurse practitioner from doing something referred to in subsection (2)(a) or (b) if, at the time it is done, the medical practitioner or nurse practitioner also informs the person about the following —
- (a) the treatment options available to the person and the likely outcomes of that treatment;
 - (b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.
- (4) Nothing in subsection (2) prevents a health care worker from providing information about voluntary assisted dying to a person at the person's request.
- (5) A contravention of subsection (2) by a registered health practitioner is unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.
- (6) Subsection (5) overrides section 10(1).
- (7) A contravention of subsection (2) by a provider, as defined in the *Health and Disability Services (Complaints) Act 1995* section 3(1), is taken to be unreasonable conduct described in section 25(1)(c) of that Act.

Chair, I appreciate your guidance in enabling us to deal with the issue immediately after we dealt with the amendment in the name of Hon Martin Pritchard, MLC. I have already indicated during consideration of the previous amendment the reasons that the government is supportive of the amendment standing in my name. For those reasons, I will not go over them again. I hope to receive the support of the chamber.

Hon AARON STONEHOUSE: Thank you, Mr Chairman, for the opportunity to discuss this amendment immediately after the last, and for the latitude that was provided to discuss aspects of this amendment during the consideration of the last amendment. We have already canvassed this pretty well. One issue I did not get a chance to talk about when we discussed the previous amendment is that when we talk about vulnerable people, we often talk about people with a disability, people who are susceptible to suggestion, the elderly, and people in a situation in which there is a power imbalance. I mentioned this in my contribution to the second reading debate or perhaps the clause 1 debate, but I am concerned about cultural and language differences when discussing voluntary assisted dying with a patient, and the cultural attitudes towards a medical practitioner's authority. Different cultures and societies have different views about the authority of a medical practitioner. A discussion about something may be viewed by some people as an explicit recommendation, and I have a bit of a concern about that. We normally try to be very sensitive about cultural differences when it comes to Indigenous Australians, but I am also concerned about migrant communities, in which, in some instances, there might be more emphasis on family or on the authority of somebody who holds a position, such as a doctor or a policeman or some other official position. It is very important that we look at the risk of undue influence through the lens of not just vulnerable people with a physical or cognitive impairment, but also people who are vulnerable merely because of cultural attitudes towards that relationship.

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Leaving that aside for now, looking at the amendment currently before the chamber, in some ways, this is a better way of addressing that issue than the amendment we discussed a moment ago. It is perhaps in some ways a little more onerous, but it ensures that when a discussion is had about voluntary assisted dying and it is initiated by the medical practitioner, there is also an obligation on that medical practitioner to provide information about palliative care at the same time. This amendment probably does a better job of enabling a patient to be informed about their options. However, I mentioned previously that if a patient initiates a conversation on voluntary assisted dying, under this proposed clause there is no obligation on the medical practitioner to provide information about palliative care, from my reading. Is there, somewhere else in the bill, an obligation on medical practitioners to provide information about palliative care when having a discussion about voluntary assisted dying?

Hon STEPHEN DAWSON: Proposed new subclause (3) seeks to address the context in which voluntary assisted dying may be raised with a patient. The member will note in that subclause the holistic approach by which the medical or nurse practitioner can raise voluntary assisted dying.

In relation to the member's last question, the coordinating practitioner and the consulting practitioner are required to present information about palliative care options under clauses 26 and 37.

Hon NICK GOIRAN: This amendment in the minister's name, now before the chamber, introduces a new term, "health care worker". What is the difference between a health care worker and a health practitioner?

Hon AARON STONEHOUSE: While the minister is seeking advice to answer that question from Hon Nick Goiran, I might wrap up my contribution to the debate on this amendment. I can see that the minister is right that under clause 26, there is an obligation on a coordinating practitioner. The clause begins —

If the coordinating practitioner is satisfied that the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters —

There follows a list of care and treatment options.

However, it is at a different stage. That is not necessarily a problem, but I think it might be worth recognising that. Clause 26 refers to the point at which a medical practitioner has become a coordinating practitioner and has assessed the eligibility of a patient, and that is when the coordinating practitioner has to ensure that the patient is informed about palliative care, whereas new clause 9A taken in its entirety refers to ensuring palliative care is raised at the initial stage. The conversation seems to be happening at two different times. Under new clause 9A, it would be raised during that initial conversation with the patient; whereas, under clause 26, it is at a later stage. I do not think that causes a problem necessarily. I want to point it out so that we are clear about when that conversation happens. I do not think it is a problem necessarily because in new clause 9A, we are talking about a situation in which the medical practitioner raises VAD and initiates the conversation. It is therefore incumbent on them to also talk about palliative care in that same conversation, whereas clause 26 would cover situations in which a patient goes to a medical practitioner who assesses their eligibility. If they are determined to be eligible, then they can begin the conversation about palliative care. They happen at different times but that is because the conversation may be initiated in different scenarios. I feel fairly satisfied about new clause 9A and the provisions under clause 26 working together to ensure the patients are notified about their options of palliative care. On that basis, I am happy to support new clause 9A at this stage.

Hon STEPHEN DAWSON: I thank the member for his comments.

Back to the question asked by Hon Nick Goiran, a "health care worker" definition is wider than a "health practitioner" definition. A healthcare worker is a person who may be unregistered and is providing health services; a healthcare worker's role is broader.

Hon NICK GOIRAN: I am not sure that is what the minister said to us the other day. I appreciate that it is difficult because the advisers are probably interchangeable; nevertheless, I draw to the minister's attention a very detailed discussion we had about clause 4, "Principles". He will see in clause 4 that the words "health practitioner" or "health practitioners" are used, from my count, on three occasions. The minister might remember that I suggested that it might be a drafting error and should read "registered health practitioners". He said no, that he did not want to do that; the government had purposely put in "health practitioners". When I asked why we do not define that, the minister said that we did not need to define it, and we had a big dialogue. At first, I asked whether "health practitioner" was defined anywhere in the Western Australian statutes and the minister said no. I think I probably even asked him a second time and he said no. Later on, we were told, "Sorry, that advice to the house was wrong; 'health practitioner' is defined in Western Australian law." We continued to have a dialogue about that and the intent of the government to purposely make sure that it is "health practitioner", not "registered health practitioner".

One of the examples the minister gave me was social workers. So convinced I was of his position to include social workers, that I even moved an amendment to add "social worker". Being an amendment in my name, the government

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was not supportive of it, which is, of course, its right. Given this latest definition of “health practitioner”, I am curious to know where a social worker fits in that mix. It seems to me that the bill now has “registered health practitioner”, “health practitioner” in clause 4 and now “health care worker”. Where does a social worker fit in that mix?

Hon STEPHEN DAWSON: I am advised, honourable member, that there is no inconsistency in what I said the other day and what I have said now. A social worker who provides a healthcare service can be a health practitioner. Essentially, a social worker could be a health practitioner or healthcare worker. As part of what the member has asked, does he want me to go back over the definition of, or the professions that are covered by, a registered health practitioner?

Hon Nick Goiran: No.

Hon STEPHEN DAWSON: Okay. Good.

Hon NICK GOIRAN: Minister, what is an example of a class of person who is a healthcare worker but not a health practitioner?

Hon STEPHEN DAWSON: I have an answer for the honourable member, but I am seeking to go further, so, if he does not mind, we will pause for a second rather than me giving him a quick answer and then him asking for further advice. I want to be able to give the member a full answer.

I am told the example would be health support staff in an aged-care setting—potentially, someone with a certificate III.

Hon NICK GOIRAN: Minister, proposed new clause 9A(5) states —

A contravention of subsection (2) by a registered health practitioner is unprofessional conduct ...

The contravention of new subclause (2) could be by somebody other than a registered health practitioner. For example, if we look at the definition of “health care worker”, we see it includes —

(b) any other person who provides health services or professional care services.

What is the penalty for that class of person if they contravene new subclause (2)?

Hon STEPHEN DAWSON: I am told that the rest would be covered by new subclause (7). The honourable member can read that for himself.

Hon NICK GOIRAN: Is the minister’s advice to the chamber that the class of person under new clause 9A(1)(b) is the same as a provider under new subclause (7); that the classes of people are identical and there is no person who is outside those classes?

Hon STEPHEN DAWSON: I am told that the definition of “provider” is very broad; and, yes, they would be covered.

Hon NICK GOIRAN: Why does the new clause 9A(1)(b) that the minister wants us to agree with not refer to a provider as defined in section 3(1) of the Health and Disability Services (Complaints) Act 1995 and instead uses the words “any other person who provides health services or professional care services”? Why was that decision made?

Hon STEPHEN DAWSON: We did not use the word “provider” because provider under the Health and Disability Services (Complaints) Act 1995 also includes a body. The bill focuses on the individual, so we did not use the word “provider” in new clause 9A(1)(b).

Hon NICK GOIRAN: I do hope, minister, that a Western Australian healthcare worker who is not a registered health practitioner understands that, because if they do not, it will be taken to be unreasonable conduct.

I do not know whether other members have received a letter from Dr Anil Tandon about this issue, but I received one today. It is dated 20 November. I do not know whether the minister has seen it. Of course, Dr Anil Tandon is a very, very experienced palliative care specialist in Western Australia. He is highly regarded and highly respected. Dr Tandon has, on multiple occasions, presented to the Parliamentary Friends of Palliative Care. I did not realise he had such an interest in new clause 9A until I read his letter this morning. This is what he said —

Dear Honourable Members

...

We represent a network of 800 health professionals who have serious concerns around the introduction of euthanasia and physician assisted suicide bills in Australia. We write to you especially concerned about the **New Clause 9A** from the Minister for Agriculture —

I pause there to note that I think that is a typographical error by Dr Tandon; I think he means the Minister for Environment —

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... representing the Minister for Health, suggesting to move **458/NC9A Page 10, to insert Subsection 3 & 4.**

The suggested additional sub-clauses are too broad and open the door for unethical behaviour, and potential for undue and dangerous influence of the therapeutic relationship toward a patient's decision making, by potentially allowing a health practitioner to initiate a discussion around VAD.

The additions suggested by the Minister for Agriculture —

Which, for the benefit of Hansard, really should read “Minister for Environment”, but that is what the letter says —

... are unnecessary and will extend the scope of Clause 9 and potentially compromise the safety of WA citizens, and particularly the vulnerable, in its application. **We respectfully ask for the subsections 3 and 4 to be removed and for Clause 9 to be clear in its instruction that NO health professional or health care worker should initiate a discussion on VAD.**

The **Victorian Act, Clause 8** clearly states:

Voluntary assisted dying discussions must not be initiated by registered health practitioner.

1) A registered health practitioner who provides health services or professional care services to a person **must not**, in the course of providing those services to the person —

(a) Initiate discussion with that person that is in substance about voluntary assisted dying; or

(b) In substance, suggest voluntary assisted dying to that person.

(2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person's request.

Our concerns are especially supported by the recent findings of Royal Commission into Aged Care Quality and Safety, and additional findings for those with disabilities ... The need for clarity around this and the potential for harms are further supported by worldwide, recognised evidence about the influence of the therapeutic relationship and care application in regards to the desire to die and outcomes ... and also in terms of what constitutes ethical medical behaviour.

Yours sincerely,

Dr Anil Tandon

My question is: has the government received this letter; and, if so, what is its position in response to it?

Hon STEPHEN DAWSON: I have not received it, and to the best of my knowledge the government has not received it; certainly, my advisers are unaware of it. That is the status. While I am on my feet, I again make the point that the new clause 9A that stands in my name on the supplementary notice paper came about following consultation with the Western Australian branch of the Australian Medical Association. As we have discussed previously, whether it is people with disability, Aboriginal people, members of Parliament or, indeed, doctors, there is a variety of views out in the community in relation to this bill; some are supportive and others are not. But certainly, I have not received that letter.

Hon NICK GOIRAN: I have received the letter and I take seriously the views of the very learned and respected palliative care specialist Dr Anil Tandon. For those reasons, I will move to amend the Minister for Environment's amendment 458/NC9A. I move —

New clause 9A — To delete proposed new clause 9A(3) and 9A(4).

The DEPUTY CHAIR (Hon Adele Farina): I might take this opportunity to ask Hon Nick Goiran whether he wants to table the letter he referred to.

Hon NICK GOIRAN: Yes, I take this opportunity to seek leave to table this document under the authorship of Dr Anil Tandon. It is dated 20 November 2019.

Leave granted. [See paper 3417.]

The DEPUTY CHAIR: Members, the copy of the amendment to the new clause moved by Hon Nick Goiran has been distributed, so we are able to proceed.

Hon NICK GOIRAN: Briefly, by way of explanation, those members who have a copy of the amendment will see that part of it is typed and part of it is handwritten. The reason that is the case is that yesterday, when I considered the amendment that had been foreshadowed by the honourable minister, it struck me that proposed subclause (3) should be struck out. However, today I received the letter from Dr Anil Tandon, which has been tabled, and I encourage members to look at that letter, because it ultimately forms the basis of my amendment to the amendment,

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and it suggests that proposed subclause (4) should also be removed. For those reasons, I have moved the amendment on the amendment that stands in my name.

Hon STEPHEN DAWSON: I thank Hon Nick Goiran for tabling a copy of that letter. It is interesting to note that although the letter says it represents a network of 800 health professionals, they are in fact doctors from right across Australia—New South Wales, the Australian Capital Territory, Victoria and other jurisdictions, as well as Western Australia. We do not support the amendment that stands in the name of Hon Nick Goiran, because it will essentially widen the amendment that was proposed by Hon Martin Pritchard and remove any ability for a medical or nurse practitioner to carry out a fundamental role of providing all available options to a patient.

Hon AARON STONEHOUSE: I was out of the chamber on urgent parliamentary business when Hon Nick Goiran discussed the reason for his amendment to the amendment. I understand a letter has been circulated and I will read it in a moment. At a glance, if we removed proposed new clauses 9A(3) and 9A(4), it would take us right back to what we were discussing in Hon Martin Pritchard's proposed new clause 9A. The minister just said that his new clause 9A is broader than Hon Martin Pritchard's proposed new clause 9A. Is there the intention here to merely replicate what would have been achieved by Hon Martin Pritchard's new clause or will the proposed changes that Hon Nick Goiran has moved in his amendment somehow create a better or lesser version of what was proposed in Hon Martin Pritchard's new clause?

Hon NICK GOIRAN: That is a very good question from the honourable member. My view is that the proposed new clause, if amended, would be a superior version of the excellent proposed new clause moved by Hon Martin Pritchard. I say that for one reason: as I said to members earlier, my concern is steering. Hon Martin Pritchard's proposed new clause would have prevented steering by registered health practitioners. My amendment will be wider than that, as identified by the honourable minister, because it will prevent steering by healthcare workers. For that reason and for the same rationale previously, I support that.

Amendment on new clause put and negated.

Hon MARTIN ALDRIDGE: I know this is a little difficult, because we started debate on another proposed new clause and now we are dealing with this one. If I am not mistaken, I heard the minister say when he responded to Hon Martin Pritchard that one of the reasons the government did not support his proposed new clause was that there was no other statutory provision that provided for a restriction on the doctor–patient relationship in the way that Hon Martin Pritchard had anticipated. If that is the minister's argument, would it still not be relevant to the proposed new clause before the chamber, which is standing in the minister's name now, that this would be the first occasion that we would be inserting into statute some restriction on that patient–doctor relationship?

Hon STEPHEN DAWSON: What I said was that Victoria has a prohibition that was not supported by the joint select committee or the ministerial expert panel. I also said that Victoria is the only jurisdiction in the world that wholly prohibits health practitioners from starting a conversation about voluntary assisted dying.

Hon MARTIN ALDRIDGE: Thank you for clarifying that, minister, because I certainly heard something else.

I understand that with respect to “nurse practitioners”, which is mentioned in this proposed new clause for the first time in subclause (3), it was the ministerial expert panel's recommendation that they be given a greater role, to which the government took a different approach. If I am not mistaken, nurse practitioners can only be administering practitioners; they cannot be consulting or coordinating practitioners. Why is it then that nurse practitioners are relevant in the context of this new clause if indeed their role is confined to that of an administering practitioner? I am not sure that initiating a discussion would be relevant at the point when a nurse practitioner is about to administer.

Hon STEPHEN DAWSON: The member is correct; they can be only administering practitioners. The inclusion here is about the senior role of nurse practitioners and their training and experience, which makes them appropriate to carry out this responsibility.

Hon NICK GOIRAN: In what circumstances would a nurse practitioner inform a person about the treatment options available to the person and the likely outcomes of that treatment? Is this something a nurse practitioner would usually undertake in the course of their duties?

Hon STEPHEN DAWSON: I am told that a nurse practitioner who is working with someone with an advanced or a progressive illness could provide them with information.

Hon NICK GOIRAN: They can provide them with information. My question was: in what circumstances would a nurse practitioner inform a person about the treatment options available to the person and the likely outcomes of that treatment? That is the language used in the bill. In what circumstances would they do that?

Is it something that they routinely do or is it outside the scope of their normal duties? If it is outside the scope of their normal duties, that is fine.

Hon Aaron Stonehouse; Hon Stephen Dawson; Hon Nick Goiran; Hon Rick Mazza; Hon Adele Farina; Hon Martin Pritchard; Hon Alison Xamon; Hon Alannah MacTiernan; Hon Tjorn Sibma; Hon Jacqui Boydell; Hon Simon O'Brien; Hon Martin Aldridge

Hon STEPHEN DAWSON: I am receiving further information, but it is probably worthwhile me putting on the record exactly what a nurse practitioner is. A nurse practitioner is a person who is registered under the Health Practitioner Regulation National Law (WA) Act in the nursing profession and endorsed as a nurse practitioner. In order to be so endorsed, the person must first be a registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must also have completed an approved postgraduate master's degree. In Australia, the registered nurse must have 5 000 hours of advanced clinical experience before they are eligible to be endorsed as a nurse practitioner by the Nursing and Midwifery National Board of Australia. On top of this, the bill requires that to be eligible as an administering practitioner, a nurse practitioner must have practised for at least two years post-registration as a nurse practitioner and must have the requirements approved by the CEO. Therefore, yes, it is within the scope of a nurse practitioner to provide information within a clinical context on the treatment options available to a patient.

Hon NICK GOIRAN: It is also about the likely outcomes of that treatment. I have emphasised now that it is those two things together. I want to be clear that the things we are saying they would have to do are actually within the remit of a nurse practitioner.

Hon STEPHEN DAWSON: I am told, yes, honourable member.

Hon MARTIN ALDRIDGE: I think Hon Nick Goiran went to this issue with respect to the definition of "health care worker" earlier, but I am just trying to understand the application of new clauses 9A(5), (6) and (7). New subclause (5) relates to a registered health practitioner and new subclause (7) relates to a provider as defined in the Health and Disability services (Complaints) Act 1995. Is the way that "health care worker" has been defined the reason that we have to override clause 10(1) of the bill through new clause 9A(6)? Is my understanding correct? I am trying to understand the interplay of new subclauses (5) to (7) and clause 10.

The DEPUTY CHAIR: I might just take this opportunity to remind members to keep the audible conversations very low or to leave the chamber if they are having private conversations, because it is making it very, very difficult to follow the debate.

Hon STEPHEN DAWSON: Clause 10(1) says that a practitioner is capable of constituting professional misconduct, whereas new clause 9A goes further and says it is unprofessional conduct in that it is a breach.

Hon MARTIN ALDRIDGE: Thank you minister; that makes it clear. Would new subclauses (5), (6) and (7) when read together cover all the people who it is anticipated will fall within the definition of "health care worker"?

Hon STEPHEN DAWSON: Yes.

Hon MARTIN ALDRIDGE: I have just one last question. This is obviously an amendment standing in the minister's name, so it is a government amendment. I want to quote from a second reading contribution by a government member given on 15 October 2019, who said —

This legislation has been developed over the past two or so years. I acknowledge the extensive work that has been put into it, from the health minister right through to the Joint Select Committee on End of Life Choices. I acknowledge the tremendous amount of work that was done by that committee and also by the Ministerial Expert Panel on Voluntary Assisted Dying. Due to the fine work put in by those dedicated people, I am satisfied with the provisions of this bill and I will be supporting it without amendment through the house. The Agricultural Region and its voters want this bill passed, as does the broader community. I think the broader community is satisfied with the bill as presented.

They are the words of Hon Darren West, who is a member of the government, on Tuesday, 15 October 2019. Does the minister know whether Hon Darren West is supporting his amendment in light of his comments on that date?

Hon STEPHEN DAWSON: It is inappropriate to ask me how any member might be voting on this bill.

Hon Martin Aldridge interjected.

Hon STEPHEN DAWSON: That is not an appropriate question to ask me. The member will know how honourable members are voting if we ever get to a vote on this clause.

Several members interjected.

The DEPUTY CHAIR: Order, members! The minister has the call.

Hon STEPHEN DAWSON: I reiterate that the government has always indicated that it would give consideration to proposed amendments.

Hon Michael Mischin: No, it hasn't.

Hon Aaron Stonehouse; Hon Stephen Dawson; Hon Nick Goiran; Hon Rick Mazza; Hon Adele Farina; Hon Martin Pritchard; Hon Alison Xamon; Hon Alannah MacTiernan; Hon Tjorn Sibma; Hon Jacqui Boydell; Hon Simon O'Brien; Hon Martin Aldridge

Hon STEPHEN DAWSON: Yes, I have said that. We have listened to members.

Several members interjected.

The DEPUTY CHAIR: Order, members!

Hon STEPHEN DAWSON: We have listened to members and stakeholders, such as the WA branch of the Australian Medical Association. We have engaged with them about their genuine concerns. In that context, this amendment appears on the supplementary notice paper in my name.

Hon NICK GOIRAN: I turn to my last question on this issue. I take the minister to new clause 9A(3) and paragraphs (a) and (b). Does the medical or nurse practitioner have to inform the person about both (a) and (b) or one of (a) and (b)? Obviously, if the practitioner does anything wrong, they will be guilty of unprofessional conduct. Do they have to do both or one of the things to avoid unprofessional conduct?

Hon STEPHEN DAWSON: They have to do both.

Hon NICK GOIRAN: Given the severity of what is happening here, after the word “treatment;”, should there be an “and” to make it clear to the practitioners that they will have to inform the person of both those things? If the minister provided a handwritten amendment, we could deal with it on the spot. With all goodwill here, there could be some pretty serious consequences, and I think the addition of that one extra word would be appropriate.

Hon STEPHEN DAWSON: I agree with Hon Nick Goiran. I am very happy to get a copy of supplementary notice paper 139 from one of our fantastic staff in the chamber so I can handwrite the amendment on it and we can progress.

The DEPUTY CHAIR (Hon Adele Farina): To ensure that members are aware of what is occurring, the minister has agreed to add the word “and” after new subclause (3)(a), so that it will read —

- (a) the treatment options available to the person and the likely outcomes of that treatment; and
- (b) ...

That will be incorporated into the minister’s new clause that has been moved. Is that correct?

Hon STEPHEN DAWSON: Sorry, Madam Deputy Chair, I was not listening to you. I was trying to seek the guidance of the assistants. Could you ask that again, please?

The DEPUTY CHAIR: Is it the minister’s intention to move this amendment inserting a new clause 9A with that word included?

Hon STEPHEN DAWSON: Yes, that is my intention.

The DEPUTY CHAIR: The minister seeks leave to amend his new clause 9A, to include the word “and” after new subclause (3)(a).

New clause, by leave, altered.

New clause, as altered, put and passed.

Committee interrupted, pursuant to standing orders.

[Continued on page 9147.]

Sitting suspended from 4.14 to 4.30 pm