ACTS AMENDMENT (ADVANCE HEALTH CARE PLANNING) BILL 2006

Consideration in Detail

Resumed from 19 September.

Clause 11: Parts 9A to 9D inserted -

Debate was adjourned after Mr M.P. Whitely had moved the following amendment -

Page 17, after line 5 - To insert -

110UA. Non-disclosure of unregistered advance health directive

(1) In this section -

"unregistered advance health directive" means an advance health directive that is not registered in accordance with Section 110RA.

(2) Subject to subsection (3), any person who does not disclose the existence of an unregistered advance health directive cannot be charged with any criminal offence resulting from that failure to disclose.

(3) Subsection (2) does not apply to any health professional within the meaning of the *Civil Liability Act 2002* section 5PA, who is involved in providing treatment or other professional services to the patient.

Mr M.P. WHITELY: This debate has been resumed after a lengthy break. We had a deal of debate about the amendment in my name. Basically, the amendment was motivated by a concern I shared with others that the legislation effectively obliges family members and friends to disclose the existence of a living will when the act of disclosure would effectively end the life of a loved one, and any family member or friend who failed to do so, so motivated by love, would be open to a charge of either assault or procurement of assault and liable to criminal prosecution. That concerned me and others. The intention of the amendment was to achieve a level of protection for family members who, acting out of love, hid the existence of a living will to extend the life of their loved one. The intention of the amendment was not to protect health professionals such as doctors and nurses who are involved in the delivery of health care, because they have a professional obligation; and the intention of the amendment was not to protect those who failed to disclose the existence of a living will to gain financial advantage. It was simply to protect those acting out of love who wanted to extend the life of their family member. There have been some discussions over a period with the Minister for Health. I will now take my seat and let the minister talk about some ideas that he has. I then anticipate that I will seek leave to withdraw my amendment. However, at this stage I will let it stand.

Dr K.D. HAMES: It was an excellent tactic to put off the debate on this legislation for such a long time because, apart from the clause that we are now discussing, I have forgotten the rest of the bill and all the issues and all the points that we worked through. Nevertheless, I was in agreement with the member for Bassendean and his amendment to clause 11. The minister was not. Therefore, we reached a minor impasse in working out how we could go forward with this legislation. My view was that I may write an advance health directive and give it to my daughter, for example. That advance health directive may say that if I am unconscious and taken to hospital, I do not want to have any treatment; I want to be left to die, if that is what will happen. My daughter, with that health care directive in her pocket, may not want me to die, and so she may not tell the doctor that I have written an advance health directive. Under the legislation, she could be charged with assault or procurement of an assault by the doctor. Therefore, the doctor who saved me would in effect have assaulted me because I had given an advance health directive in which I directed that my daughter should tell the health professionals about the existence of that directive. Therefore, she would be liable to prosecution. I strongly disagreed with that being the case. I thought that the amendment moved covered the situation, but the minister was strongly opposed to it and suggested, in fact, that he would not proceed with the legislation if that amendment were to remain. I want the legislation to go ahead. Therefore, I guess it was up to somebody to compromise. We attended a meeting, which was arranged by the minister, with Mr Robert Cock, who has proposed an alternative solution that I am in favour of. I cannot speak for the member for Bassendean, but I am sure he will say that he is in favour of it. The minister has a copy of that, and I presume he will read it into *Hansard*. That satisfies my concerns; that is, I am satisfied that, if that were the case, my daughter would not be prosecuted.

Mr J.A. McGINTY: I am very appreciative of the constructive role played by the members for Bassendean and Dawesville in helping to resolve this issue.

Dr K.D. Hames: And the member for Maylands.

Mr J.A. McGINTY: Yes. No-one wants a person to be prosecuted before the courts for what is exclusively an act of love - perhaps misguided, but nonetheless an act of love. That is not consistent with the general approach to the criminal law in this state. That is the point that was raised by each of the members to whom I have just referred. The members for Maylands, Bassendean and Dawesville met this evening with the Director of Public Prosecutions, Robert Cock, QC. Although I was not there, my understanding is that the Director of Public Prosecutions has indicated that his prosecution guidelines are very much influenced by the wish of the Parliament when it comes to legislation. He said that if it was the wish of the Parliament, he would amend his prosecution guidelines to deal with the very issue that has caused this bill to become somewhat bogged down over the past few months. In particular the Director of Public Prosecutions has indicated that he would amend his prosecution guidelines to insert a new section 33A that will read as follows -

> **33A. Relevant Factor in Special Cases**
>
> In considering the public interest in prosecuting a person arising out of a failure to disclose an advance health directive, it is not in the public interest to prosecute a person for any offence arising out of a failure to disclose an advance health care directive if the non-disclosure was motivated by love and affection for the dying person, to extend the life of the dying person and without any intention to benefit financially.

That seems to me to cover the issue that was raised by the amendment moved by the member for Bassendean, and supported by the member for Dawesville. In particular, this will ensure that the Director of Public Prosecutions will not maintain a prosecution against a person whose actions, if I can use a general phrase, are motivated by love and affection. Such a person will not end up in court as a result of his or her actions. In my view that deals in a very effective way with the issues that have been raised during this debate. I thank those members whom I have mentioned, and the Director of Public Prosecutions, for the way in which this matter has been addressed. I had a serious problem with inserting into this legislation a provision that to my mind would have had the effect of undermining the whole purpose and intent of the legislation. This is a very effective way of dealing with the issue. Hopefully, on that basis, all members of this place will be able to walk away from this debate and say we have achieved what we want to achieve.

Mr M.P. WHITELY: Would the minister consider incorporating this information in the second reading speech when the bill gets to the upper house so that it is absolutely clear that this is the intent of the Parliament?

Mr J.A. McGINTY: Yes. As the member knows, courts take notice of what is said in the second reading debate. I will undertake to ensure that this is incorporated in the second reading speech that is made in the upper house, assuming the bill is passed in this place.

Mr J.B. D'ORAZIO: Can the minister explain why this could not be incorporated as an amendment to the legislation? This proposed guideline by the Director of Public Prosecutions is very clear. Rather than just allow the Director of Public Prosecutions to make this part of his prosecution guidelines, why not also incorporate it as an amendment to the legislation?

Dr G.G. JACOBS: Proposed subsection (3) states that subsection (2) does not apply to a health professional. What would be the nature of the prosecution, and what would be the legal consequences or penalty, for a medical practitioner for the non-disclosure of an advance health directive?

Mr J.A. McGINTY: I will answer the two points raised. Firstly, this has nothing to do with medical practitioners. They derive their protection from a later provision in the bill. This has to do with the actions mentioned in the amendment still before us, which was moved by the member for Bassendean. It is about protecting not medical practitioners but family members and loved ones. This clause does not deal with that particular matter.

In answer to the member for Ballajura, this legislation seeks to promote the idea of living wills and the way in which they would be given statutory form. I have a problem with rewriting the legislation so that anyone who cheated or deceived would have nothing done to him. That is how it has to be categorised. It may have been motivated by love and affection, but it still involves somebody going out of his way to defeat the purpose of the legislation. I have real difficulty in writing that into the legislation. I have no difficulty in saying that it is a matter of discretion vested in the Director of Public Prosecutions and that he may, in the public interest, not prosecute in those circumstances. I am not supportive of writing the provision into this legislation. That is the basis upon which we have addressed this issue to try to find a practical solution to it. I think we have found it.

Mr M.P. WHITELY: I am satisfied by the assurances from the Minister for Health and the Director of Public Prosecutions. Having said that and for the reasons outlined, I seek leave to withdraw my amendment.

Amendment, by leave, withdrawn.

Ms K. HODSON-THOMAS: I require some clarification. Given that the member for Bassendean has been given leave to withdraw his amendment and I did not oppose that, I must advise that I have some concerns, which are similar to those raised by the member for Ballajura. The Minister for Health has outlined that the Director of Public Prosecutions will use his discretion in such cases. Am I able to speak further on this?

The ACTING SPEAKER (Mrs J. Hughes): I am advised that if the member's comments fall within the question that the clause stand as printed, she may speak on it.

Ms K. HODSON-THOMAS: I have a similar mindset to that of the member for Ballajura. I have listened to the comments made by the minister. I apologise for being tardy in getting into the chamber in time to hear all his comments. I understand that the discretion will be given to the Director of Public Prosecutions and that, in the public interest, the Director of Public Prosecutions has given a commitment that he will not prosecute a loved one should he or she decide to not disclose that an advance health directive was given by another person. That indicates to me a real lack of commitment to the intent of the amendment moved by the member for Bassendean. I was not privy to the meeting held with the DPP. It seems to have been decided that only certain members would be privy to that meeting. I find this extraordinary. I would like to think that a loved one - whether it be a son, daughter, wife or husband; whoever it might be - who clearly has great concern for his or her partner, father, mother, child or whoever the person is and who knows of an advance health directive but loves the other person so much as to not reveal it should have his or her position protected in the legislation. As legislators, we should ensure that that was clearly articulated in the legislation and not simply left to the discretion of the Director of Public Prosecutions.

Mr M.P. Whitely: What the Minister for Health read out will be an amendment to the prosecution guidelines which, I understand, will then be gazetted.

Mr J.A. McGinty: And binding on the DPP.

Ms K. HODSON-THOMAS: And binding on the DPP? Would the minister mind clarifying that for me by way of interjection, because I was not in the chamber for that part of the debate?

Mr J.A. McGinty: Certainly. The Director of Public Prosecutions has indicated that he will be very much influenced by the will of the Parliament. The will of the Parliament has been expressed in this place today. He will now amend the Statement of Prosecution Policy and Guidelines by inserting a special provision to deal with this very issue. The amendment to the prosecution guidelines states -

> In considering the public interest in prosecuting a person arising out of a failure to disclose an advance health directive, it is not in the public interest to prosecute a person for any offence arising out of a failure to disclose an advance health care directive if the non-disclosure was motivated by love and affection for the dying person, to extend the life of the dying person and without any intention to benefit financially.

That is the very issue that was raised. We will gain protection for those people.

Ms K. HODSON-THOMAS: How will the DPP determine whether the person was motivated by love and affection for the dying person? He will look at it in a clinical way. I am not a lawyer, but I understand that lawyers must be dispassionate; they look at facts. How will they make the determination that the person was motivated by love, for example?

Mr J.A. McGinty: That is what judges and prosecutors do every day of the week to determine someone's motivation. The question of motive is very much a part of dissecting any crime. They are expert at it. They will apply their minds to all the circumstances of a particular case to determine whether it truly was an act of love or whether there was an ulterior motive, such as financial gain or something of that nature. It is my view and the view of the other members who were party to the discussion with the DPP that this amendment to the prosecution guidelines will deal completely with the issue of providing protection, particularly to loved ones, in their dealings with the advance health directives of people who are dying.

Ms K. HODSON-THOMAS: I am not convinced. The minister makes a very plausible argument.

Mr J.A. McGinty: The member is very hard if I am not convincing her.

Ms K. HODSON-THOMAS: I am probably one of the most easygoing members in this place. However, I am still not convinced. I would prefer that the amendment be included in the legislation to ensure that people in this situation are covered by the legislation. That is the role of members of Parliament. Obviously, I know I will not win on this count, but I am certainly not convinced.

Dr K.D. HAMES: I will again explain why members agreed to this amendment to the prosecution guidelines. I agree with the member for Carine. I would prefer that it be included in the legislation, but the minister will not accept its inclusion in the legislation.

Ms K. Hodson-Thomas: It is the soft option.

Dr K.D. HAMES: It is the soft option. The minister has said that he will not proceed with the bill if it is included in the legislation. I want the bill to proceed, so I have to either back down or stick to my guns and not have the bill proceed. I have made the choice that I would rather that the bill proceed. I am satisfied with that. We must think about the practical outcomes. If I wrote an advance health directive and did not want my child to be in that position, I would register the directive. There is an option for people to register their health directives, and not give them to their sons or daughters who will be in the difficult position of having to produce it or not produce it at the appropriate time. Therefore, I will register my health directive. However, a person could have written an advance health directive indicating that he or she did not want to be kept alive and wanted to be allowed to die, but the child might not tell the health professionals that a health directive existed because the child loved the parent and wanted him or her to be kept alive. That is a very clear-cut direction. The opposite might be the case. Someone might have done an advance health directive to be kept alive at all costs. Regardless of what the person ends up like, he or she might want to be kept alive but does not disclose it. Then it will be important for the prosecutor to decide whether the relative loved the person and wanted the person to die quickly even though the person did not want to die or whether there was some financial benefit to be gained from a will. It would be extremely rare for someone to sign an advance health directive to be kept alive. That is not the purpose of the legislation. It is extremely unlikely someone would do an advance health directive for that purpose, but we never know. That is what the minister wants to cover. The Director of Public Prosecutions has said that the guidelines are based upon the will of the Parliament. They are gazetted and he is required to follow them. That gives me sufficient reassurance to support this, even though I would have preferred it to be in legislation.

Ms K. HODSON-THOMAS: I hear what the member for Dawesville says and I appreciate that he supports some of my sentiment. I have no real experience with the office of the DPP. I read the prosecution policy and guidelines only recently. Will the minister explain to me how frequently they are changed? I have heard that they are changed at the will of the Parliament. Perhaps the minister can give me an indication so that I can feel a level of reassurance. I am not sure that I will be reassured, but I would like to understand how frequently they are changed and whether we can feel the certainty we would like to feel on this issue. I would prefer to see it as a clause in this legislation. I am not trying to delay the process, so I will keep my comments brief.

Mr J.A. McGINTY: The current guidelines are dated 2005. I understand that they are not changed every year, but from time to time, to reflect changed circumstances.

Ms K. Hodson-Thomas: Is that policy change from government or the Parliament?

Mr J.A. McGINTY: It is done by the DPP without input from government. However, in drawing up those guidelines, the DPP takes into account significant changes made by the Parliament. If this legislation is passed, it will be a significant change to an area of the law, and the DPP has indicated how he will respond to that on the passage of the legislation.

The most recent changes to this came about as a result of other legislative changes made to the law, particularly the criminal law and the prosecution processes. As the member for Carine is aware, they were significant changes to criminal law in this state. Criminal law procedures in particular have been rewritten. These guidelines were rewritten to reflect that change in the law. It happens from time to time, but not frequently.

Ms K. Hodson-Thomas: Does that not come back to Parliament for our review?

Mr J.A. McGINTY: No.

Mr M.P. Whitely interjected.

Mr J.A. McGINTY: Frankly, I do not know. This is the Statement of Prosecution Policy and Guidelines 2005. I suspect it is disallowable because this Statement of Prosecution Policy and Guidelines is issued pursuant to section 241 of the Director of Public Prosecutions Act 1991 and will become operative from the date of its gazetting. Whether it is disallowable is certainly something that is -

Mr M.P. Whitely: That is my understanding from the meeting I had with Robert Cock.

Mr J.A. McGINTY: The member for Bassendean's information is no doubt more accurate than mine.

Dr K.D. Hames: When this clause is added as a result of the meeting and the legislation going through Parliament, that does not get changed or reviewed, does it, without an alternative new direction being given by Parliament to that legislation?

Mr J.A. McGINTY: That is right.

Dr K.D. Hames: Because the clause is specific.

Mr J.A. McGINTY: Yes, specifically relating to this legislation.

Dr K.D. Hames: A new public prosecutor is not going to come in and say that he does not like it and change it. That is the point I am making.

Mr J.A. McGINTY: No. It would be extraordinary for any future Director of Public Prosecutions to take that point of view, because of the importance of taking into account the intention of Parliament expressed in this legislation and its debates leading up to making the legislation in the first place.

Mr T.G. Stephens: Personally, I think that is a load of absolute nonsense.

Mr J.A. McGINTY: The member is welcome to that view.

Mr B.S. WYATT: I just want to say something in respect of the DPP guidelines. Having had something to do with them, I can say that changes to them are very rare. They are usually driven over time out of court decisions and practice changes.

Mr T.G. Stephens: Or ideology.

Mr B.S. WYATT: No, very rarely ideology.

Mr T.G. Stephens: Or a desire to steamroll the Parliament.

Mr B.S. WYATT: No, not at all.

Mr T.G. Stephens: Absolutely a desire to steamroll the Parliament.

Mr B.S. WYATT: Not at all, because guidelines are not law. The member for Central Kimberley-Pilbara will find that a criminal code - like any other criminal code in any other state - gives prosecuting guidelines to the DPP. A criminal code like this can only ever be a skeleton; we cannot simply legislate for every response. The DPP wants, as bad as it may sound, a certain amount of flexibility in a prosecution. The DPP must be able to decide whether an offence warrants in the public interest a prosecution. That happens for homicides through to drug offences. There are guidelines that the DPP looks to, and that is what we have in this bill. If we legislate to not find people criminally responsible when problems occur, we will remove any flexibility in a prosecution. There is no legislation that I am aware of that exempts a prosecution for a criminal offence; rather, this is the flip side, which is what I think the minister is saying in this bill. We see it in all DPP guidelines, not just this state's guidelines. They are not changed willy-nilly, because they are very rarely changed, but the element of flexibility comes in. I cannot foresee a prosecution emerging in this scenario unless an element of maliciousness or financial gain is involved. I just want to let the member for Carine know that I worked in the DPP's office for a long time and in all that time I was involved in only one such case. That case involved feedback from the courts, from all lawyers, from the DPP and no doubt - although I am not sure - from the Attorney General's office.

Mr T.G. STEPHENS: I wish the member for Victoria Park well in his expectation of officers of government and officers that hold the position of DPP into the future. I have been a member of this place only a short time, but I have experienced a DPP who deliberately, in my view, altered the prosecution policy of government to steamroll the Parliament. Those members who have been members of this place for only a brief period will have experienced that alteration. Changes to the prosecution policy suddenly delivered a result in the house aimed at a public policy outcome quite in contradistinction to the assurances given to the house in the debate.

Dr K.D. Hames: Can you give us an example?

Mr T.G. STEPHENS: The member for Dawesville knows the example.

Dr K.D. Hames: Abortion!

Mr T.G. STEPHENS: The member for Dawesville should not try to pretend that members do not know the example. They know only too well the example. It is the example of the changed prosecution policy that applied to the practice of abortion in this state. Reflect for half a second on it, for goodness sake! Do not try to pretend. Suddenly a prosecutor wanted to achieve parliamentary action to pursue an ideological perspective. That might have reflected the majority viewpoint of the Parliament at the time; quite clearly it did.

Mr R.C. Kucera interjected.

Mr T.G. STEPHENS: He had the options. He laid the charges.

Mr R.C. Kucera: No, the charges were laid -

Mr T.G. STEPHENS: He drove the charges.

Dr E. Constable: They were not laid by him.

Mr T.G. STEPHENS: It was the decision of the DPP.

Mr J.A. McGinty: It was the decision of the police.

Dr E. Constable: The police laid the charges. The DPP decided to prosecute.

Mr T.G. STEPHENS: It was the prosecution policy of the DPP, which had been modified in response to his ideology and which produced an outcome in this Parliament. Just reflect on our recent history. I am stunned. I did not realise that this debate was coming on tonight. People will clearly have the opportunity of delivering whatever they want to deliver through this Parliament. I do not know why I did not notice that this was an order of the day for today. I understood that we were dealing with urgent, outstanding matters of government priority before the house rose for the session. I did not realise that we were suddenly dealing with matters that would be determined by a free vote of the house. I thought we were clearing up the legislation to deal with the urgent agenda of the government. We are suddenly dealing with arguments being put before the house based on a specious recollection of the history of the place. If people want to run an argument in defence of the legislation, let us at least deal with honest arguments. Let us at least deal with the history of the way in which the prosecution policy of the DPP steamrolled the Parliament into a change of the legislative regime for handling the community's sensitivities to human life.

Madam Acting Speaker (Mrs J. Hughes), I have been in this Parliament when the Chair has stopped the wagging of heads of people at the table who were supporting ministers and held that they should deal with their job professionally as assistants to the minister and stop their commentary on the rights of members of Parliament in the handling of legislation; and when the Chair has shut up the comments that came from officers at the table.

Ms K. HODSON-THOMAS: I am quite certain that the member for Central Kimberley-Pilbara has not completed his remarks. I would like to hear him continue.

Point of Order

Mr J.A. McGINTY: Even though this is a free vote, people are still required to address the issue before the Chair. The member for Central Kimberley-Pilbara is taking himself off on what might be regarded as the broadest possible tangent that could be raised in a second reading debate. The member is not addressing clause 11 of the bill.

The ACTING SPEAKER (Mrs J. Hughes): I ask the member to please confine his remarks to the clause before us.

Debate Resumed

Mr T.G. STEPHENS: Thank you, Madam Acting Speaker. In response to the debate on this point, all I would say to those at the table is that I do not need their wagging heads and commentary on my contribution to this house. I got elected to this place and they did not. I will have my say and I do not need their commentary.

This debate, in my view, does not need to be rushed through in the dying days of this Parliament. In reference to the particular point of the question of the prosecution policy of the DPP, we have seen -

Point of Order

Mr J.A. McGINTY: I again raise the same point of order.

The ACTING SPEAKER (Mrs J. Hughes): The member will confine himself to clause 11. I also observe that advisers are there to advise the ministers and are not there to include themselves in the debate. The member will confine his comments to the clause and not include the advisers.

Mr T.G. STEPHENS: Madam Acting Speaker, I hope that you are giving them that same advice.

Mr J.A. McGinty: She is giving you advice on how you ought to conduct yourself.

The ACTING SPEAKER: Thank you, minister. The member for Central Kimberley-Pilbara will deal with clause 11.

Debate Resumed

Mr T.G. STEPHENS: The DPP has the opportunity to utilise his prosecution policy in ways that should be checked by this Parliament. In the past that prosecution policy has been deliberately utilised in ways to achieve an outcome that -

Point of Order

Mr J.A. McGINTY: Madam Acting Speaker, I again raise the same point of order.

The ACTING SPEAKER (Mrs J. Hughes): I ask the member to please make his point on clause 11 very clear.

Debate Resumed

Mr T.G. STEPHENS: In reference to clause 11, in the earlier debate there was a discussion about the prosecution policy of the DPP, and the Minister for Health gave answers about that. It may not suit the minister and the house to share the opposite viewpoint to the minister about the answer that he gave, but it is my profound recollection of the history of the way -

Point of Order

Mr J.A. McGINTY: Madam Acting Speaker, I again raise the same point of order. I suggest that you sit the member down because he is abusing your direction to him.

The ACTING SPEAKER (Mrs J. Hughes): The amendment that was put before the house has been withdrawn due to the comments of the Minister for Health. Leniency was given to the member for Carine to pursue an explanation as she was not in the chamber earlier to hear the debate. If the member does not have any different comments to make on this clause, I suggest he wind up his remarks.

Debate Resumed

Mr T.G. STEPHENS: Madam Acting Speaker, I will take your advice and wind up my remarks. We are progressing a piece of legislation on the assurances that were given by the Minister for Health that the prosecution policy of the DPP may be disallowable. It has not been my experience as a legislator that the prosecution policy has not been disallowable.

Mr R.C. Kucera: It is based on a false premise.

Mr T.G. STEPHENS: No, it is not.

Mr R.C. Kucera: I was involved in that matter you were talking about. It is based on a false premise. That matter came before the DPP fully charged.

Dr E. Constable: That's the usual procedure.

Mr R.C. Kucera: Exactly. There was nothing -

Mr T.G. STEPHENS: With a changed prosecution policy.

Mr R.C. Kucera: The fact that a matter came before the court changed the legislation. It wasn't the DPP's policy. It is based on a false premise.

Mr T.G. STEPHENS: A changed prosecution policy did not apply in reference to that matter. The assurances given to the house by people with a different viewpoint from me do not put me in the comfort zone that the member has on this issue. What we have seen from the history of this matter is that the prosecution policy was modified to achieve a particular legislative outcome. It was done without the opportunity of either house to respond to that reality. Legislative reform was then introduced in response to that set of circumstances.

Mr R.C. Kucera: It wasn't a change of policy; it was a set of circumstances that came about. It wasn't a change of policy; it was forced upon them. A prima facie case presented. He had no option but to -

Mr T.G. STEPHENS: That is one way of presenting that set of circumstances. It is not the only way to look at that set of circumstances.

Mr R.C. Kucera interjected.

Mr T.G. STEPHENS: I do not accept that view of history. I do not think that the history of that set of circumstances is recorded in the way that discussion proceeded at that time.

Mr J.A. McGINTY: I move -

Page 18, lines 14 and 15 - To delete "section 110S(3) or (4)." and substitute -

section 110S(4).

This amendment is purely consequential on an earlier amendment that was moved. It has no other significance.

Amendment put and passed.

Mr J.A. McGINTY: I move -

Page 20, lines 4 to 16 - To delete the lines and substitute -

(a) the patient's spouse or de facto partner if that person -

(i) has reached 18 years of age; and

(ii) is living with the patient;

(b) the patient's nearest relative who maintains a close personal relationship with the patient;

(c) the person who -

(i) has reached 18 years of age; and

(ii) is the primary provider of care and support (including emotional support) to the patient, but is not remunerated for providing that care and support;

(d) any other person who -

(i) has reached 18 years of age; and

(ii) maintains a close personal relationship with the patient.

This amendment arose out of part of the second reading debate. Many members, in particular the member for Dawesville, raised the question of the order in which the persons responsible ought to be listed. Some considerable concern was expressed that the carer appeared before the nearest relatives. We have sought to come up with a new order in which a health professional will turn to various relatives or next of kin, as they are sometimes referred to. The formulation in this amendment better reflects the debate and concerns that were raised by members. Paragraph (a) of the amendment begins with a patient's spouse or de facto partner; paragraph (b) lists the nearest relative who maintains a close personal relationship with the patient; paragraph (c)(ii) lists the primary carer; and paragraph (d)(ii) lists any other person who maintains a close personal relationship with the patient. That better reflects the views expressed by a number of members during the course of the second reading debate, to the extent that I can remember back that far.

The ACTING SPEAKER (Mr A.P. O'Gorman): Before I give the call to other members, I must make something clear. The amendment that the Minister for Health just moved is to delete lines 4 to 16 on page 20 of the bill and to substitute an alternative set of words. The member for Carine has also signalled her intention to delete line 16 on page 20. The minister's amendment would usually be moved in two parts: firstly, to delete lines 4 to 16; and, secondly, if the motion was successful, to insert the proposed words. However, the passage of this amendment would preclude the member for Carine from moving her amendment. Therefore, to preserve the member for Carine's right to move her amendment, I propose that a test vote be conducted. Rather than move to delete lines 4 to 16, as proposed by the Minister for Health, I will initially move that lines 4 to 15 be deleted. If this motion is agreed to, we can move to delete line 16, as proposed by the minister. However, if this motion is disagreed to, the member for Carine will be able to move her amendment.

Ms K. HODSON-THOMAS: I indicate to the house that I will not move the amendment standing in my name.

Dr K.D. HAMES: This amendment addresses my concerns. I will remind members of the concerns some of us had. The original legislation listed a de facto partner as the first person who was responsible for making a treatment decision and the spouse was listed as the second person. At the time, it was argued that the spouse should be listed first because a spouse should always be listed first rather than a de facto, bearing in mind that someone who had a spouse but who was separated might have a new partner. In that case, it was argued that the new part partner should be listed before the spouse, and we were happy with that explanation. However, the minister has addressed that matter also by listing spouse or de facto together, which solves those sensitivities. The main objection to proposed section 110ZD(3)(c) in the bill was that it stated -

> a person who regularly provides, or arranges for the provision of, domestic services and support to the patient, but is not remunerated for doing so;

That person preceded the patient's nearest relative. Therefore, the lady who lived next door and who did the cleaning was given priority over the son or daughter of the patient. The reason for that was that the son or daughter might be estranged from the person concerned. We should not assume estrangement at the start; sons and daughters should be given the opportunity not to be estranged. This is a better combination. It puts spousal

and de facto partners first, followed by the nearest relative - provided that he or she has maintained a close personal relationship with the patient, and so on. I am happy with the amendment.

Amendment put and passed.

Mr J.A. McGINTY: I move -

Page 20, lines 17 to 23 - To delete the lines and substitute -

(4) For subsection (3)(b), the patient's nearest relative is the first in order of priority of the following relatives of the patient who has reached 18 years of age -

(a) the spouse or de facto partner;

(b) a child;

(c) a parent;

(d) a sibling.

(5) For subsection (3)(b) and (d)(ii), a person maintains a close personal relationship with the patient only if the person -

(a) has frequent contact of a personal (as opposed to a business or professional) nature with the patient; and

(b) takes a genuine interest in the patient's welfare.

(6) For subsection (3)(c)(ii), a person is not remunerated for providing care and support to the patient although the person receives a carer payment or other benefit from the Commonwealth or a State or Territory for providing home care for the patient.

This amendment is a further elaboration on the issue of who is responsible. It defines the patient's nearest relative in order of priority, starting with spouse or de facto partner and continuing with child, parent, sibling etc. It then extends to a person who maintains a close personal relationship with the patient. It is a further definition of the amendment that we have just adopted for the purposes of this provision.

Dr E. CONSTABLE: Will the minister define "frequent contact"? It is not unlikely in this day and age for an elderly widow to maintain close contact with her children even though they do not live in this state through telephone calls, snail mail, e-mail and other means. Children may have a close relationship with their parents even though they do not live geographically close. Do those people fit into the minister's definition of "frequent contact"?

Mr J.A. McGinty: Yes, they do.

Dr E. CONSTABLE: Therefore, frequent contact does not have to be physical face-to-face contact or when a person visits a patient in his or her home. Frequent contact can happen in a number of different ways. It is important to spell that out, because most people would consider frequent contact to be physical face-to-face contact. I also refer to the part of the amendment that reads "takes a genuine interest in the patient's welfare." That is a very subjective statement that could be interpreted in a number of ways. Will the minister elaborate on that so that anyone making a decision once this bill becomes law understands what is meant by those phrases, because they are not particularly clear?

Mr J.A. McGINTY: The broad intention is not to limit it to somebody who has face-to-face contact. It might well be someone who rings every second day and who maintains contact electronically. In the general course of events, it will be someone who cares for the patient and that would obviously require in most circumstances a physical presence. The second point is that we have tried to distinguish between a meddlesome neighbour, for instance, and somebody who genuinely cares for the person. These are the sorts of issues that the Public Advocate and the Guardianship and Administration Board must deal with on a regular basis to ascertain as best they can the person who has a real interest in the welfare of the person and to whom the person would turn for direction on medical matters. The way we have reworded it is to get a more sensible and logical flow of the order in which particular classes of people are to be considered. When it comes to somebody who is not a direct lineal relative but who cares for an elderly person, to use the example that has been given, we look for a genuine interest in that person; that is, somebody who is supportive. How do we ascertain who is genuine -

Dr E. Constable: It is very subjective.

Mr J.A. McGINTY: It is, but people are skilled in making exactly that assessment. It is the sort of decision that is currently made by people such as the Public Advocate and the Guardianship and Administration Board in determining those quite often competing claims. They have to deal with them on a regular basis when two sections in a family might be competing over who makes the decisions about a mother, who may no longer be

capable of making decisions for herself. They are the sorts of decisions that need to be made and we have sought to spell out in the legislation the way that has to be approached in those circumstances. It is subjective but I think the intent is quite clear: it has to be someone who has a genuine interest in the welfare of the individual, ahead of someone who might be an interfering or meddlesome neighbour.

Dr E. Constable: The interfering or meddlesome neighbour may well have been a neighbour for 40 years and genuinely care for the person even though they may be meddlesome.

Mr J.A. McGINTY: Sure. People with odd personalities are not excluded from the scope of the legislation.

Mr R.F. Johnson: You are all right then!

Mr J.A. McGINTY: I have enough people on my side to fight without fighting the member for Hillarys as well!

It is an attempt to articulate the best interests of the person about whom decisions are to be made.

Ms S.E. Walker interjected.

Mr J.A. McGINTY: We have deleted the carer as such and replaced it with a more generic description. That is the issue I have just been debating with the member for Churchlands. I am sorry; I retract what I have just said. The amendment that has already been carried includes "carer" in it, but then it goes on to refer in paragraph (a) to the spouse or de facto partner, in (b) to the nearest relative and in (c) to the primary provider of care and support. We are now defining with greater particularity the nearest relative and the person who maintains a close personal relationship with the person, which is spelt out. A person who maintains a close personal relationship with someone comes after a carer. I am sorry; my initial response to the member's question was incorrect.

Ms S.E. WALKER: The reason I raised this is the case of Mrs Buzolic, who has not been prosecuted, and will not be, for the latest matter. She was the woman who fleeced an elderly person of about $400 000 and was imprisoned by the District Court. Then she married another of my constituents, but never lived with him, and is now receiving his Veterans' Affairs pension. What is going to happen? I recently went to an elder abuse conference in Victoria and it is clear that people who are elderly and living alone in their homes will be targeted by people who come in and care for them. I want to put on record that that is a concern when one looks at these provisions. I have seen it happen in my community and it has been quite tragic. Also, that will lead to the fact that there is no appeal to the State Administrative Tribunal on these matters. It makes it very relaxed. For instance, some family members may say that a woman has come into the home and taken over and their father is smitten with her and it is they who want to fill the position outlined in the bill. It will be a real issue of concern. If people come in, they will want to see that person terminated so that they can get their assets.

Mr J.A. McGinty: I agree that that it is an issue.

Dr E. CONSTABLE: I think this issue was raised by the member for Dawesville. Is it possible for a person to have a spouse and a de facto partner at the same time?

Mr J.A. McGinty: Yes, so I am told.

Dr E. CONSTABLE: If that is the case, what happens to subsection (4)(a) of this amendment? It refers to the "spouse or de facto partner". Is there an order there?

Mr J.A. McGINTY: I suspect that a great number of people are in exactly that situation. They are legally separated and are living in a de facto relationship. They are still married, but have a de facto partner. That is the easy, but most common, case. Obviously we would go to the person with whom the patient was living, and that would be the de facto, even though the patient is still legally married. For whatever reason many people do not wish to get divorced and they live in a de facto relationship.

Dr E. Constable: Does that take precedence when an estate is being disputed?

Mr J.A. McGINTY: It is the same issue there.

Dr E. Constable: It is not necessarily the person with whom they are living who gets the estate?

Mr J.A. McGINTY: No. The question is: who makes the decisions for this person at a critical time in his or her life? That is different from the problem of distribution, which can be based on more general principles. If it involves a former husband and wife, ultimately the property would be divided between the married couple, and a de facto partner of more than two years would also have some rights to claim on the property as well. That has been the law in this state for some years.

Dr E. Constable: You have dealt with the easy case. There are more difficult cases.

Mr J.A. McGINTY: The hard case is a situation in which a husband and wife are living together and the husband maintains a de facto partner concurrently. That is where it becomes far more complicated. To whom does one turn?

Dr E. Constable: What is your advice on this because under proposed subsection (4)(a) of the amendment the spouse and the de facto partner will have equal billing. Who is the person who will make the decision?

Mr J.A. McGINTY: As a general indicator we would look to whom the person was living with and maintaining as his or her partner.

Dr E. Constable: This person is maintaining two people.

Mr J.A. McGINTY: Yes. There may be degrees to which the patient is maintaining each person, and that would need to be taken into account.

Ms S.E. Walker: He would be a bigamist.

Mr J.A. McGINTY: Effectively he would be a bigamist. If there were a dispute over which of those two people in that more difficult situation it would be, the legislation provides for the State Administrative Tribunal to determine which person should be given priority. Hopefully, that would not arise in everyday transactions.

Dr E. Constable: We don't know, do we?

Mr J.A. McGINTY: No. That is a fair call, because I know that there are people in exactly that situation.

Dr E. Constable: These are the tricky ones that we need to seriously pick up and talk about in this debate, because, as you say, they are the difficult ones and someone will have to sort it out.

Mr J.A. McGINTY: Yes.

Amendment put and passed.

Ms K. HODSON-THOMAS: There is an amendment in my name on the notice paper. I am trying to remember where we were up to. That is the problem when we come back to deal with legislation months later and try to pick up the thread. It is very hard to grasp it again. I have been looking through some of my paperwork, but I will seek clarification from the minister in case I missed out something. I believe an amendment had been moved by the member for Swan Hills and that that had been deferred to a later stage. That amendment related to the terminology "medical practitioner". I will seek clarification of that issue first, so that members will begin to grasp where we are up to in the debate on the legislation. I will then move my amendment, if that is possible.

Mr J.A. McGINTY: We are all struggling a little because of the lapse of time. There were two propositions. The member for Swan Hills proposed that advance health directives should be witnessed by a medical practitioner. I think that was quite separate from the purpose of the member for Carine's amendments.

Ms K. Hodson-Thomas: I understand that. I am just trying to get some clarification. Was that deferred? Were we to go back and deal with that?

Mr J.A. McGINTY: It was deferred. The member for Swan Hills' definition of a medical practitioner was deferred, depending upon the outcome of the witnessing requirements. We have dealt with that and it was defeated. Therefore, the member for Swan Hills' amendment will not be proceeded with.

Ms K. HODSON-THOMAS: I move -

> Page 22, lines 9 and 10 - To delete the lines and substitute -
>
> **"medical practitioner"** means -
>
> (a) a person not being a body corporate who is registered under the *Medical Act 1894*; or
>
> (b) a body corporate which is registered under the *Medical Act 1894*.

There are a number of amendments on the notice paper in my name to delete the words "health professional" and substitute "medical practitioner". As members will note, they relate to the same issue. Therefore, I will speak to all of them. If this amendment fails, it is my intention to withdraw all those other amendments.

The ACTING SPEAKER (Mr A.P. O'Gorman): They are consequential on this amendment being passed.

Ms K. HODSON-THOMAS: Yes. I understand that. I have had some discussions privately with the member for Dawesville. He does not support this amendment. He believes that the term "health professional" covers nurses. Any person, whether a nursing professional or a doctor, who is dealing with people who are at the end of their lives would have a true understanding of that set of circumstances. I understand the view of the member for

Dawesville, and he will probably speak on this issue in his own right. I have no intention of delaying the discussion in the chamber. I believe members are not committed to this. I could stand here and try to convince other members. However, we have been dealing with this legislation for some time, and most of us know that the government has the numbers in support of this legislation. I will not be supporting the legislation. However, that is my choice, because we have a free vote on this bill. I would have liked this amendment to go through. Other members have a different view. My concern is that the term "health professional" is very broad and far reaching. It covers people ranging from podiatrists to psychiatrists. I would have preferred to include medical practitioners in the definition. Perhaps there might even have been an opportunity to include nursing professionals in the definition. However, I certainly believe medical practitioners should be included.

Mr J.A. McGINTY: If this legislation dealt only with end-of-life treatment by a medical practitioner, I would agree with the amendment the member is proposing. However, this legislation deals with any person who is mentally incapable of making health care decisions. Substitute decision makers, who are appointed under either a living will or an enduring power of guardianship, will make health care decisions on behalf of such a person, perhaps about their dental treatment, and perhaps even about their podiatry treatment. This legislation deals with all health professionals who are providing treatment to the patient. It does not deal only with the issue that has been the centre of our debate; that is, end-of-life decision making. I suspect this legislation will have its major impact in end-of-life decision making. However, it includes all health care decisions, which essentially means it will include all health professionals.

Dr G.G. JACOBS: I support the amendment moved by the member for Carine. It may not seem surprising to some members that I would be supporting this amendment. This legislation deals with very important issues. Those issues are significant enough to warrant the purest definition of what we are dealing with. The minister has said that this legislation deals with more than just end-of-life decision making. However, as the member for Carine has suggested, the term "health professional" is too generic. It could include physiotherapists and occupational therapists. In my previous experience I have obviously not dealt with the particular concept of an advance health directive. However, from my previous experience these issues are of such importance that they should be the concern of any medical practitioner who is bound by the Medical Act 1894. In fact, we should be directing this legislation to the concept of medical practitioner rather than adopt a generic definition of health professional.

Dr K.D. HAMES: With due respect, members have not looked specifically at what this part of the bill is about. It is about treatment decisions for patients under legal incapacity. Proposed section 110ZI deals with urgent treatment and states -

> (1) Subsection (2) applies if -
>
> (a) a patient needs urgent treatment; and
>
> (b) the patient is unable to make reasonable judgments in respect of the treatment; and
>
> (c) it is not practicable for the health professional who proposes to provide the treatment to determine whether or not the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment . . .

A provision like this could cover an ambulance officer who has a patient but does not know of an advance health directive. The ambulance officer recognises that he has to do something and does it. It cannot be limited to a medical practitioner.

Dr G.G. Jacobs: If we cannot rely on you, who can we rely on?

Dr K.D. HAMES: I might not be there.

Dr G.G. Jacobs: If you are not going to speak up for medical practitioners -

Several members interjected.

The ACTING SPEAKER (Mr A.P. O'Gorman): Order, members!

Dr K.D. HAMES: The member needs to read the legislation.

Dr G.G. Jacobs: I have read it.

Dr K.D. HAMES: Have another look at page 23. Proposed subsection (2) states -

> The health professional may provide the treatment to the patient in the absence of a treatment decision in relation to the patient.

It is not just for doctors; it is not a matter of sticking up for doctors or not sticking up for them. The doctor might not be there at the time the treatment is required. It might be simple treatment -

Dr G.G. Jacobs interjected.

Dr K.D. HAMES: Not necessarily. The provision refers to urgent treatment. It might be a nursing home patient who has fallen out of bed and broken something and requires urgent treatment by whoever is there, whether it is the nurses or the cleaners, to try to fix whatever problem needs urgent treatment.

Dr G.G. Jacobs: That is not realistic.

Dr K.D. HAMES: I am not going to waste my time arguing with the member any more, other than to say that he is wrong.

Mr T.G. STEPHENS: I support the amendment moved by the member for Carine. I do so not only because of the arguments advanced by the member when she moved her amendment, but also because of the reply delivered to the chamber by the Minister for Health whose arguments I thought were sufficiently compelling to justify the amendment being carried.

There is a role for restricting, through this bill, participants in the process so that they are restricted to medical practitioners. That is not something that is unknown to the law as it stands minus this bill. Only tonight I had the opportunity of looking at another piece of legislation that aims at putting in place protections for people against mistakes being made on their behalf, and determining the categories of witnesses for documents that deal with matters far less important than life. There are requirements to deal with a lawyer or a medical practitioner. In dealing with life, we are required to deal with a medical practitioner. I would have thought that the arguments advanced by the Minister for Health were compelling arguments for the chamber to support the amendment moved by the member for Carine. I commend the member's amendment to the house. I am also of the view that another compelling argument has been put by the member for Carine. This debate has been brought on somewhat unexpectedly. There are other items of a compelling nature on the agenda, and I would prefer that we were not dealing with the bill at this time. There are other issues that the government has an ambition to put before the house.

The ACTING SPEAKER (**Mr A.P. O'Gorman**): The member should be speaking to the amendment moved by the member for Carine, not whether we should continue to debate the bill.

Mr T.G. STEPHENS: Yes. With reference to the amendment moved by the member, there is value in restricting the way in which the bill will impact on the law. The engagement of a medical practitioner in the process should be required under the legislation. I support the view that the member put to the house. Compelling arguments have been put by the Minister for Health. It may be that the divergence of viewpoints expressed by the members for Dawesville and Roe could more suitably be argued in a review of the proposed amendments by a committee of the house, rather than in this debate. If two medical practitioners have adopted divergent viewpoints on an amendment that will apply to their own profession -

Dr K.D. Hames: With respect, the chances of our finding a basis of agreement on this amendment do not exist.

Mr T.G. STEPHENS: The value of a committee of the house considering the bill is that it could be improved. I also am of the view that this clause has already experienced the disservice of inadequate arguments in its defence.

Dr E. CONSTABLE: At first glance, I agree that a medical practitioner should be involved in making these decisions. However, we are talking about an urgent situation. If I were a patient who had fallen out of bed and I could not see a doctor for an hour, I would want someone to make the decision to make me more comfortable and ease my pain. I agree with the member for Dawesville; often in an urgent situation there is no doctor around or it takes too long to get a doctor to the patient. The person might be in an isolated place and it might take hours to get a doctor to the patient. None of us wants a person to be left in a situation in which he or she has to wait for a doctor. I do not support the amendment, because we must take into account the practicalities of an urgent situation. Someone such as a nurse practitioner or a qualified person should be in a position to make a decision about the care of the patient.

Dr G.G. JACOBS: I have had patients at nursing homes under my care. As a medical practitioner, I would not necessarily be by the patient's bedside holding his or her hand waiting for the patient to fall out of bed. The management of the patient's care involves a medical practitioner. This is not a turf issue. There is a good argument for a medical practitioner to be involved in these issues, whether they be end-of-life issues or issues related to the management of an older patient in a nursing home who has fallen out of bed. The member for Churchlands said that the doctor might take two hours to see a patient. The management approach is referred to a medical practitioner, and I believe it is an important and integral part of this legislation. I am a little disappointed with the member for Dawesville, although I do not wish there to be any acrimony over this issue. I am sure that will not occur; nonetheless, I suggest that, just because the medical practitioner is the person central to these important decisions, it does not mean that the medical practitioner must be immediately available by the

bedside. However, in the concept of the management issues, essentially, the buck must stop somewhere. I am concerned that the member for Dawesville could suggest that the buck could stop with the cleaner or one of the carers. We are talking about an important issue of management. It is not valid to suggest that because a doctor is within two hours away, he would be precluded from being the central person in the management of these quite important - some not as important - end-of-life issues. There must be some definition that includes the medical practitioner.

Ms S.E. WALKER: I support this legislation. I have a sneaking feeling, as I said at the beginning, that it is far too relaxed in some areas. It almost has a policy behind it of shuffling us off the mortal coil more quickly to accommodate the baby boomers. I support the member for Carine's amendment. Will the member for Roe tell me whether it is contemplated under this part of the bill that a person may be in a life or death situation? Is the member for Roe saying that it is contemplated that if the medical practitioner might be two hours away, he or she can be contacted, but the management buck stops with the medical practitioner? This legislation has always worried me. On behalf of the people who find themselves in this position, such as older Western Australians or people who do not have the capacity to look after themselves, they require a much higher standard of treatment than what can be provided by a cleaner or someone who is not qualified. Most people put their trust in a medical practitioner. They want to think their medical treatment is being handled by a medical practitioner. They would be very disappointed with us as politicians if we were to fob them off to a cleaner or someone who did not have the training and did not have the final say.

Ms K. HODSON-THOMAS: I indicate my appreciation to members who have spoken in support of the amendment. As I indicated earlier, it is difficult to grasp the thread of this legislation when it has been left for months on end, and to then find ourselves suddenly thrown into dealing with it. We are talking about proposed part 9D, "Treatment decisions in relation to patients under legal incapacity". I heard the member for Dawesville's remarks and I have had a private conversation with him. I heard from the member for Roe and from the member for Nedlands, who spoke with her legal cap on, and she has a good legal brain. She looks at things much differently from me. I am looking at the issue in a practical, commonsense way. What happens now if we need urgent treatment? Do we go to a health professional; do we talk to the podiatrist; do we talk to the occupational therapist; do we talk to the dentist; or do we talk to the medical practitioner? What happens currently?

Mr J.A. McGinty: It could be urgent dental treatment, for instance, to relieve pain and suffering. That is probably the best example I can give.

Ms K. HODSON-THOMAS: I understand that. However, the terminology in the clause is far too broad. I would rather it was worded in a different way. That is the reason for my amendment. As I said, there is a difficulty in dealing with this legislation. When were we dealing with it last? How long ago was it?

Mr J.A. McGinty: It was 20 September. It is two months later.

Ms K. HODSON-THOMAS: Yes. Here we are debating it late in the evening two months later. From my perspective, I am disappointed that some members of this place are not present in the chamber. One of those is the member for Southern River, who is unwell. I want to record in this place that I hope he is recovering swiftly. He is a great contributor to debates.

Mr J.A. McGinty: Yes.

Ms K. HODSON-THOMAS: I would have liked to hear him contribute to this debate, as some of the arguments he has presented in this place have been very compelling. Having said that, the member for Swan Hills and probably other members might have supported my amendment. In any case, I want to know from the minister: what happens now? What are the circumstances? The minister can answer by way of interjection.

Mr J.A. McGinty: People will always need consent to any treatment, whether it be dental treatment or medical treatment. Obviously if somebody is involved in a major accident and it is a medical issue, it is the health professional, a medical practitioner, that you will turn to, unless one is not available, in which case you will turn to a nurse practitioner or someone of that nature. However, this clause does not cover only end-of-life medical decisions. That is the essential point of the difference in the argument on this clause.

Ms S.E. WALKER: The point is that it could cover end-of-life decisions.

Mr J.A. McGinty: Yes, it does.

Ms S.E. WALKER: The minister has included an escape clause that allows cleaners to make end-of-life decisions.

Mr J.A. McGinty: No; they must be health professionals.

Ms S.E. WALKER: What does the Civil Liability Act say? What does that cover? It refers to the meaning of "health professional". The member for Dawesville, who has carriage of this bill for the opposition, says that for people who fall out of bed it could be a cleaner. I am sorry, but I just do not think it is good enough for us as parliamentarians to inflict this clause on Western Australians.

Dr K.D. Hames: You do not think it is good enough for somebody who is legally incapacitated and falls out of bed?

Ms S.E. WALKER: No, I do not think it is good enough for us to say to Western Australians who are legally incapacitated and who fall out of bed and break a hip that it will be okay for the cleaner to look after them and give them urgent treatment. It is not okay. I do not know whether some members understand this legislation. From what the minister has said, someone must make a decision for a person in a nursing home who has a terrific toothache and needs the tooth removed. Is the minister saying that the person must be a health professional?

Mr J.A. McGinty: The health professional in that case would be a dentist.

Ms S.E. WALKER: Yes. I am asking the minister. For example, who makes the decision for someone in a nursing home who is legally incapacitated and has a toothache? Is it a health professional?

Mr J.A. McGinty: Yes, in the case of urgent treatment.

Ms S.E. WALKER: A health professional?

Mr J.A. McGinty: Yes, a relevant health professional. You wouldn't go to a podiatrist!

Ms S.E. WALKER: Okay, but if that same person comes back and during the night falls out of bed, the member for Dawesville says that it is okay for the cleaner to make an urgent intervention.

Dr K.D. Hames interjected.

Ms S.E. WALKER: I do not think so.

Dr K.D. Hames: The cleaner is not a health professional.

Ms S.E. WALKER: What if the person breaks a hip and the nurse, not the doctor who is managing that person, makes the decision?

Mr J.A. McGinty: There are no doctors in Norseman if you fall out of bed in Norseman District Hospital!

Ms S.E. WALKER: Is that not the minister's fault? That is his poor, shoddy work as the health minister. He should shoot himself in the other foot. That is what I say.

Mr J.A. McGinty: First of all the member for Hillarys and now the member for Nedlands!

Ms S.E. WALKER: The minister should be tidying up this legislation and not rushing it through. He has brought this bill on late and members might not vote for it if he does not get this part right. It is not good enough to say that a person who falls out of bed in a nursing home, and who has a doctor, can be given urgent treatment by a variety of people and have no recourse to the doctor.

Dr G.G. JACOBS: I thank you for your indulgence, Mr Acting Speaker (Mr A.P. O'Gorman). I hope I did not detect a tone of tiredness in your voice. We could call the person a generic health professional, but many situations potentially involve end-of-life decisions. In that context it is important that a health professional be a medical practitioner. As the member for Nedlands has said, the people of Western Australia deserve that. We need to tighten up the definition. It might involve a dental decision, but I suggest that unless a health professional is defined as a medical practitioner, there is the potential for a generic health professional to be dealing with end-of-life issues.

Ms S.E. WALKER: If a person is in a nursing home and legally incapacitated, would he automatically be under the care of a medical practitioner?

Dr G.G. Jacobs: Absolutely.

Ms S.E. WALKER: How would we know whether that person needed to go to a dentist? Would the medical practitioner be called in to say that he needs to see a dentist?

Mr J.A. McGinty: No is the answer to that.

Ms S.E. WALKER: The minister is not a doctor, although he would like to be. He is not really a lawyer; he is a student.

Dr G.G. Jacobs: If the patient were under my care, for example, someone from the nursing home might phone and say that the patient had a severe pain in the jaw. I would be consulted and perhaps I would determine the cause of the pain in the jaw.

Ms S.E. WALKER: Mr Acting Speaker -

The ACTING SPEAKER: The member for Roe is giving the member for Nedlands an answer by way of interjection.

Ms S.E. WALKER: Yes, but I cannot hear because of all these conversations on my left.

Dr G.G. Jacobs: The nurse would call the doctor. The doctor would have a group of patients under his care. That would not mean that he would see them every day. He might see them as a group once a week, but he would visit them individually. If there were an urgent need at any time, such as a severe pain in the jaw or any other ailment, the doctor would be called. A decision would be made about what treatment and what management would be instituted. The doctor might say that perhaps the pain was caused by a tooth and that a dentist should be consulted. That would be one of the treatment management options.

Dr K.D. HAMES: I was not going to speak on this clause, because I wanted to get on with the vote, but I have to provide for the record the alternative view to the explanation that has been given. An excellent example would be a remote Aboriginal community, such as Kiwirrkurra in the western desert. They do not have doctors.

Ms S.E. Walker: They have -

Dr K.D. HAMES: Did I interrupt the member for Nedlands?

Ms S.E. Walker: Yes.

Dr K.D. HAMES: I did not.

The ACTING SPEAKER: Order! Members need to address the Chair, not each other.

Dr K.D. HAMES: In most cases what was said by the member for Roe would be correct, but not all. That is why the legislation is currently not specific. It does not cover all cases. A nurse health professional works in Kiwirrkurra and does most of the work looking after patients there.

Mr T.G. Stephens: Not always.

Dr K.D. HAMES: They are regularly visited by the Royal Flying Doctor Service or by medical practitioners. I think they come to Kiwirrkurra once a month. There are also regular visits by dentists. If a patient is mentally incapacitated and has a pain in the jaw and a dentist visits, one would not go to the doctor and ask whether it is okay for the dentist to see this person who is in pain. One would get the dentist to have a look. The dentist is the health professional.

Ms K. Hodson-Thomas: They have a dentist up there?

Dr K.D. HAMES: They have a dentist who visits, the same as the doctor does.

Ms S.E. Walker: It can't be urgent then.

Dr K.D. HAMES: It may be urgent. It is not the case 100 per cent of the time. The member for Nedlands is trying to make one shoe fit all.

Ms S.E. WALKER: I have lived in isolation for four and a half years and I know exactly what goes on. I remember when I delivered an Aboriginal child, because there was no doctor around. We rang the doctor in Carnarvon. We got a nurse actually. What the member for Dawesville is saying does not make sense.

Dr K.D. Hames: Yes, it does.

Ms S.E. WALKER: No, it does not. I will tell him why. He is saying that a person in this remote community may be incapacitated. He is saying that when this person has a toothache and the dentist visits, it comes under urgent treatment. If it was that urgent, he would be taken to the dentist or someone would get him to a doctor. I do not accept what the member is saying.

Ms K. HODSON-THOMAS: I seek some clarification. This is my amendment. I wish to double check. I do not trust anyone in this place. The one thing I have learnt in politics is not to trust anyone. I have moved to delete lines 9 and 10 and substitute other words. The amendment moved in my name clearly indicates the words to be inserted. Is that correct?

The ACTING SPEAKER (Mr P.B. Watson): No; the words must be deleted. You have to delete the words first and then insert words.

Amendment put and negatived.

Mr J.A. McGINTY: I move -

Page 23, after line 8 - To insert -

110ZIA. Urgent treatment after attempted suicide

(1) Subsection (2) applies if -

(a) a patient needs urgent treatment; and

(b) the patient is unable to make reasonable judgments in respect of the treatment; and

(c) the health professional who proposes to provide the treatment reasonably suspects that the patient has attempted to commit suicide and needs the treatment as a consequence.

(2) The health professional may provide the treatment to the patient despite -

(a) that the patient has made an advance health directive containing a treatment decision that is inconsistent with providing the treatment; or

(b) that the patient's guardian or enduring guardian or the person responsible for the patient under section 110ZD has made such a treatment decision in relation to the patient.

Debate adjourned, on motion by **Mr T.G. Stephens**.