VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 22 November. The Chair of Committees (Hon Simon O'Brien) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

Clause 14: When person can access voluntary assisted dying —

Progress was reported on the following amendment moved by Hon Charles Smith —

Page 11, after line 10 — To insert —

(ba) the person has been assessed by a palliative care specialist who has advised the person about the palliative care and treatment options and other services available to the person to treat their pain symptoms and discomfort and address their physical, psychosocial and existential distress; and

The CHAIR: The question is that the words proposed to be inserted be inserted.

Division

Amendment put and a division taken, the Chair casting his vote with the ayes, with the following result —

Ayes (11)

Hon Peter Collier	Hon Rick Mazza	Hon Charles Smith	Hon Alison Xamon
Hon Donna Faragher	Hon Michael Mischin	Hon Aaron Stonehouse	Hon Ken Baston *(Teller)*
Hon Nick Goiran	Hon Simon O'Brien	Hon Colin Tincknell	

Noes (23)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Colin Holt	Hon Tjorn Sibma
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Alannah MacTiernan	Hon Matthew Swinbourn
Hon Robin Chapple	Hon Sue Ellery	Hon Kyle McGinn	Hon Dr Sally Talbot
Hon Jim Chown	Hon Diane Evers	Hon Martin Pritchard	Hon Darren West
Hon Tim Clifford	Hon Adele Farina	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Alanna Clohesy	Hon Laurie Graham	Hon Robin Scott	

Amendment thus negatived.

Hon RICK MAZZA: My amendment at 415/14 is a consequential amendment and can stay on supplementary notice paper, issue 9, for now.

The CHAIR: I note the intention for amendment 415/14 to remain on the supplementary notice paper for future consideration but not to be contemplated now.

Clause put and passed.

Clause 15: Eligibility criteria —

Hon NICK GOIRAN: How is clause 15 consistent with the principle set out in clause 4(1)(b)?

Hon STEPHEN DAWSON: A person will have autonomy to choose voluntary assisted dying but, of course, this will not be an absolute right for everyone. They must still meet the clause 15 requirements.

Hon NICK GOIRAN: That is quite telling, minister, because in the multitude of emails that I have received—I am sure that other members will have received a multitude of emails on this as well—it strikes me that a significant number of Western Australians do not yet understand that the bill before us will not apply to them and that they will not be eligible to access this scheme, notwithstanding the mantra that has accompanied this bill, including in the title of the Joint Select Committee on End of Life Choices report, "My Life, My Choice". Do I understand, minister, that clause 15 will restrict Western Australians' autonomy with regard to end-of-life choices?

Hon STEPHEN DAWSON: It necessarily restricts access to those who meet the eligibility criteria under this bill. There will be an 18-month implementation period and that will build in proper implementation of the criteria of the bill.

Hon NICK GOIRAN: Why has the balance of probabilities test been adopted in this bill while the Victorian act requires the highest standard of assessment, under section 9(1)(d)(iii), that the disease, illness or condition "is expected to cause death within weeks or months, not exceeding 6 months"?

Hon STEPHEN DAWSON: The probabilities test has been agreed to by the ministerial panel, including the medical experts on the panel. This concept is easily understood and has case law to support it. It provides the greatest clarity and most utility. Clinicians use this concept and the language rather than considering it as a test. For example, when considering possible diagnoses, a clinician may consider one diagnosis more probable than

another on the basis of presenting symptoms and clinical test results et cetera. With regard to the usage in the context of the bill, a clinician would be familiar enough with the concept of balance of probabilities, or more probable than not, to be able to apply it to the question at hand when possible to do so.

Hon NICK GOIRAN: Is it the case that the test that is being applied here under the Western Australian legislation is at a lower level than that applied under the Victorian legislation?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: How does the minister explain the difference between the Western Australian test and the Victorian test?

Hon STEPHEN DAWSON: We believe the WA test is appropriate for Western Australia. In Victoria, "expected to cause death" approximates more than 50 per cent. "Balance of probabilities" is clearer language. We wanted to use language that medical practitioners in Western Australia are used to.

Hon NICK GOIRAN: Is the test, in effect, the same between the Western Australian legislation and the Victorian legislation and the only difference is the choice of language?

Hon STEPHEN DAWSON: I can answer it this way: we do not believe we are lowering the standard.

Hon NICK GOIRAN: The minister in the other place said on 5 September, at page 6606 of *Hansard* —

> In terms of discussions with other parts of government, most notably our friends from the legal area, they thought that "reasonably foreseeable" was not tight enough. In ongoing discussions with the expert panel and the Department of Justice, it was decided that "balance of probabilities" provided the greatest clarity and the most utility in terms of defining this period.

How does the balance of probabilities test provide greater clarity and utility than other tests relating to a patient's prognosis, including the reasonably foreseeable test?

Hon STEPHEN DAWSON: I think I have answered that question already when I said that we are using language that medical practitioners are familiar with. When I provided an answer earlier about the balance of probabilities, I said that in regard to the usage and the context of the bill, a clinician would be familiar enough with the concept of balance of probabilities to be able to apply it to the question at hand when possible to do so.

Hon NICK GOIRAN: I have not asked that question this afternoon. I have not mentioned reasonably foreseeable until this latest question, so the suggestion that the minister has somehow answered it previously is incorrect.

Hon Stephen Dawson: I have provided the answer previously.

Hon NICK GOIRAN: The minister provided an answer about the difference between the Western Australian legislation and the Victorian legislation. I remind the minister that the Victorian legislation uses the phrase, and the test is "expected to cause death", which is different from the test of reasonable foreseeability and is different again from the Western Australian legislation. I refute any suggestion that I have already asked this question this afternoon. *Hansard* will accurately record exactly what has transpired. At no stage has there been any discussion until this last question about reasonable foreseeability. Can somebody with a 49 per cent chance of surviving more than six months be eligible to access voluntary assisted dying under this bill?

Hon STEPHEN DAWSON: I ask the member to ask his question again, please.

Hon NICK GOIRAN: Can someone with a 49 per cent chance of surviving more than six months be eligible to access voluntary assisted dying under this bill?

Hon STEPHEN DAWSON: If a person meets the six-month criterion in clause 15(1)(c) of the bill, they may be eligible if they meet all the other criteria; if not, no.

Hon NICK GOIRAN: The six-month criterion the minister referred to is at clause 15(1)(c)(ii). Would a person who has been determined as having only a 49 per cent chance of surviving more than six months meet the six-month test the minister has referred to?

Hon STEPHEN DAWSON: Doctors have to ask whether it is more probable than not that the patient will die within the requisite period. The language of medical practitioners is the balance of probability, not discrete increments of percentages—hence the language that is used in the bill.

Hon NICK GOIRAN: I move —

> Page 12, after line 3 — To insert —
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> (ia) is ordinarily resident in Western Australia; and

This amendment is the same as that moved by the member for Girrawheen in the other place on 5 September 2019, and would bring the Western Australian bill up to the standard of the Victorian legislation—specifically, section 9(1)(b) of the Victorian Voluntary Assisted Dying Act. The Victorian act contains a twofold residency test; that is, the person must ordinarily be resident in Victoria and, at the time of making their first request, must have been resident in Victoria for at least 12 months. As the Western Australian bill is currently worded, it requires only that the person must have been resident in Western Australia for 12 months at the time of making the first request. This amendment would discourage people living in states and territories where voluntary assisted dying has not been legalised from moving to Western Australia after having been diagnosed with a terminal illness, disease or condition for the express purpose of accessing voluntary assisted dying in the state. This is sometimes referred to as assisted dying tourism.

I note that the Northern Territory's Rights of the Terminally Ill Act 1995 did not contain a residence requirement and, as such, people travelled to the territory from other Australian states to request assistance to voluntary terminate life, as it was described in that act. Members may be familiar with the publication in a peer-reviewed journal titled "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia". That article detailed the cases of seven patients who made formal use of the Rights of the Terminally Ill Act 1995. Two of those patients sought euthanasia but died before the act became law, four died under the act, and one died after the repeal of the act. I specifically want to draw members' attention to case 1 in that study. Case 1 involved a 68-year-old woman who was not ordinarily resident in the Northern Territory, but who travelled there to seek euthanasia some months before the Rights of the Terminally Ill Act passed. The patient was diagnosed with a carcinoma of the caecum and, despite labelling herself as terminally ill, Dr Philip Nitschke understood her to know that there was potential for surgery to be curative and that her prognosis was good. It should be noted that although this patient moved to the Northern Territory to access voluntary assisted dying under the Rights of the Terminally Ill Act, this patient's death was not brought about by voluntary euthanasia under the act. This particular person suicided in Darwin in September 1995, only weeks after an interview on national television in which she stated that she would suicide if the regulations necessary for the operation of the RTI act were not soon made law.

The other case out of the seven that I want to draw to members' attention is case 6. Case 6 involved a woman who flew to Darwin from another part of Australia accompanied by her children. The patient in case 6 had advanced metastatic carcinoma of the breast. She had discussed euthanasia with her children, who agreed and organised her flight to Darwin. A week after arriving in Darwin, the patient in case 6 underwent euthanasia. Case 6 would be excluded access under clause 15(1)(b)(ii) of the bill before us, because the patient was in the Northern Territory for only one week rather than one year. This case still serves to indicate that people are willing to travel interstate to access voluntary assisted dying where it is legally available. The fact that the Victorian act expressly requires the patient to have been ordinarily resident in Victoria makes the Western Australian regime a more liberal one, and more likely to attract people moving interstate to access voluntary assisted dying when diagnosed with a terminal illness. It is for those reasons that I have decided to move the amendment in the precise same language and words as moved by the member for Girrawheen in the other place.

Hon STEPHEN DAWSON: The government does not support this amendment. The proposed addition does not materially add to the clause, as the clause already contains the requirement for ordinary residence of 12 months. The residency requirement under section 15(1)(b) of the bill requires —

> the person —
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> (i) is an Australian citizen or permanent resident; and
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> (ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

The types of things that may be considered when determining ordinary residence is the person's physical presence with a degree of continuity, routine or habit; their social and living arrangements; and the maintenance and location of their assets et cetera. The Victorian act includes an additional limb in its residency requirement that the person be ordinarily resident in Victoria. This addition is not included in the WA bill as it is legislatively redundant; that is, to say that a person must be ordinarily resident and ordinarily resident for 12 months is essentially repeating the same requirement twice, because the test of ordinary residence necessitates that a time frame be built into it, specified or unspecified. For example, the Australian Taxation Office has a test of ordinary residence whereby the time frame is not specified. Nonetheless, the ATO generally accepts a time frame of six months for a person to be deemed ordinarily resident in Australia, based on criteria I referred to previously. The test of ordinary residence differs across Australia dependent on the assessing party. To be clear, the WA bill specifies that at the time of making a first request, the person must have been ordinarily resident in WA for at least 12 months. The WA bill is not more liberal.

Hon NICK GOIRAN: Why was the period of 12 months selected?

Hon STEPHEN DAWSON: Recommendation 3 in the Ministerial Expert Panel on Voluntary Assisted Dying's final report states —

> For access to voluntary assisted dying, the person must have been ordinarily resident in Western Australia for 12 months at the time of making the first request.

That recommendation was considered. We felt it was an appropriate time period and included 12 months in the bill before us.

Hon RICK MAZZA: With all due respect to the mover of the amendment, I am struggling to find some relevance in the amendment before us about ordinary residence in WA. To me, 12 months is a fairly long time. My understanding of this legislation is that someone's death will be imminent and if they need to be a resident here for 12 months, that is quite a considerable time. I do not think that there is any point in a person who is diagnosed with a terminal illness, who might have six months to live, moving to Western Australia if they have to wait 12 months to access voluntary assisted dying. If the mover of the amendment had also included deleting subclause (1)(b)(ii) and left "ordinarily resident in Western Australia" to some other definition, I could kind of understand it, but at the moment I am struggling somewhat to understand the relevance of this amendment.

The other issue is that someone could genuinely move to Western Australia and, after being here for three months, find that they have a terminal disease and are given only three to six months to live. At the moment, they would not be eligible; under this legislation, they would not be able to access VAD. With that, unless there is a plausible explanation for including this amendment, I am struggling with why I would support it.

Hon NICK GOIRAN: I indicate to Hon Rick Mazza that I find his comments to be fair and reasonable. I am committed to making sure that this house has an opportunity to consider all the amendments that were moved in the other place. We all know that the government's attitude at that time was that no amendments be considered under any circumstance. Things have evolved; things have changed since then—for the better, I might add—and it is appropriate that this chamber also has the opportunity to consider all those amendments, including this one, of which the genesis was the member for Girrawheen.

Hon ADELE FARINA: Could the minister explain to me what sort of evidence the doctor would need to rely on to establish that the criteria in 15(1)(b) is satisfied?

Hon STEPHEN DAWSON: I believe I have provided this information previously, but I am happy to provide it again. The patient may demonstrate this with a range of documents such as a driver's licence, rental or property agreement, employment records and registration to vote. They are some of the ways to do it.

Amendment put and negatived.

Hon MARTIN ALDRIDGE: Recommendation 3 of the ministerial expert panel's final report is that in exceptional circumstances there should be a provision for application to the State Administrative Tribunal for relief on compassionate grounds from the strict requirement of residency for 12 months. I think that is what Hon Rick Mazza just went to with his hypothetical scenario of somebody who has legitimately moved to Western Australia, is three months into their residency in this state and for all other reasons would be eligible but for the fact that they had not been ordinarily resident in WA for 12 months. On that basis, and in my view, I think that the ministerial expert panel's recommendation that a person can make an application to the SAT on compassionate grounds is reasonable. Why is it that the government has not accepted the ministerial expert panel's recommendation in this regard?

Hon STEPHEN DAWSON: That recommendation was considered. The government felt that this was a liberal approach, and we respectfully declined that approach.

Hon MARTIN ALDRIDGE: I was hoping for a bit more thorough response, given the amount of advice the minister just took. I find it difficult to understand the government's acceptance of its current position but not that of the ministerial expert panel. That could ultimately expose Western Australians to suffering—which is what we are trying to avoid through the passage of this legislation—because of the mere fact that they have not been ordinarily resident for 12 months, notwithstanding that they have legitimately lived here and have not moved here, as other members have outlined, simply to access the regime. Because they do not tick this box that requires residency for 12 months, there is no other option available to them. I do not understand the government's opposition to allowing a Western Australian to apply to the State Administrative Tribunal to put a case for the exceptional circumstances that apply to them. It seems odd to me that the government would not accept this recommendation. I was hopeful the minister may have perhaps identified some practical implications. Obviously, one of those might be that the process of making an application to the State Administrative Tribunal is probably not an easy process to undertake, given the circumstances facing the person. However, if that is the only option the person has, they

could weigh up the risks and the benefits of pursuing that course of action. The government has not accepted this recommendation from the ministerial expert panel. It is not clear to me why; I think that the panel's recommendation is sound.

Hon STEPHEN DAWSON: I am not sure that the honourable member was looking for an answer. Again, I say the bill has necessary restrictions on limitations. Where we have landed with the bill is an area that we thought was appropriate. I take the member's point of view on board, but that was not the reason for landing where we have.

Hon NICK GOIRAN: I move —

> Page 12, line 9 — To insert after "progressive" —
>
> and incurable

The CHAIR: I will mention that a new supplementary notice paper has arrived, with the regularity with which they have been arriving during the course of this debate. This is issue 10. We note one omission, but that will not affect us now and will be reinstated.

Hon NICK GOIRAN: For the sake of clarity, members, I seek to include here a provision that the disease needs to be incurable. This amendment is the same as the one moved by the member for Girrawheen in the other place on 5 September this year. Section 9(1)(d)(i) of the Victorian legislation requires that the patient's disease, illness or condition be incurable in order for them to qualify for access to voluntary assisted dying. On 5 September in the other place, at page 6602 of *Hansard*, the member for Cottesloe noted —

> … there are a range of absolutely treatable medical conditions that if left untreated, will result in death.

The member for Girrawheen in the other place offered the example of a person suffering from gangrene. In this example the person is told that if they do not have their leg amputated, they will die from the infection, but if they undergo the amputation, their life will be saved. On 5 September 2019, the Minister for Health responded to this scenario —

> … in some respects, the treatment might, to that patient, be worse than the prescribed cure. I am thinking in particular of someone who might have a tumour of some form that might be technically operable, but that operation would be highly compromising to that person's quality of life and could potentially leave them in a very debilitating, if managed, state of affairs. From that point of view, I guess the Premier was trying to underscore the principles of what we have here; that is, if a person has a terminal disease that, on the balance of probabilities, will take their life within six months, and that person is adjudged to have the capacity to make a decision about the future of their end-of-life choices and an understanding of the implications of that, they should be able to access voluntary assisted dying. It will end suffering and, in that sense, it provides a rational and humane outcome. It is unlikely that someone will choose death in situations in which they could have a higher quality of life. There is a bit of creeping language around this that people are somehow trying to slip through the net to advance a form of self-emasculation, for want of a better description. This is not that; this is about providing agency to someone whose life will end within six months, who is suffering intolerable pain, and who, within the safeguards that we have crafted in this legislation, should be able to have better outcomes in respect of their end-of-life choices.

In the words of the Minister for Health, it is unlikely that someone will choose death in situations in which they could have a higher quality of life. I think it is pertinent that the minister said it is "unlikely"; of course, that means it is possible under this bill, as it is currently drafted. My amendment, the genesis of which was the member for Girrawheen's amendment in the other place, seeks to provide clarity for assessing practitioners while making it clear that it was the intention of this Parliament in drafting this law that voluntary assisted dying would not be available to people with lifelong medical conditions who, upon ceasing their medications, become terminally ill.

Another medical condition that can be terminal if left untreated is diabetes. A patient with type 1 diabetes who ceases taking their insulin will become terminally ill. If it is left untreated, it can lead to diabetic coma and death. We know from the Oregon Health Authority's 2018 annual report that 11 people with diabetes ended their lives through the voluntary self-administration of a lethal dose of medications expressly prescribed by a physician for that purpose under that state's Death with Dignity Act; that is, diabetes is listed as the underlying illness that resulted in these 11 people ending their lives under the Death with Dignity Act. I hope members would agree with me that it is not the intention of this place for Western Australians living with chronic conditions, the symptoms of which are managed by medical treatment, to access voluntary assisted dying by ceasing their medical treatment and entering the terminal phase of their disease, illness or condition. It is for those reasons that I have moved this amendment, in the same words as the amendment moved by the member for Girrawheen on 5 September this year.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. The term "incurable" has not been used, as it is largely a reiteration of the existing criteria. It would also unfairly exclude those for whom there is the right to refuse a treatment that may cause intolerable suffering or other adverse outcomes. The Victorian act requires that, in addition to the diagnosis criteria, the patient must also be diagnosed with a disease, illness or medical condition that is incurable. The exclusion of the requirement for a patient to have an incurable condition, illness or disease reflects the view of the Ministerial Expert Panel on Voluntary Assisted Dying. This criterion has not been included in the Western Australian bill for two reasons. Firstly, the WA bill already requires that the person has a disease, illness or medical condition that is advanced, progressive and will cause death within a time frame of six or 12 months, on the balance of probabilities. Secondly, it is not appropriate to require a person to exhaust all treatment options that may result in the disease, illness or medical condition being completely cured, but as a result of which the person would significantly compromise or lose their quality of life. Every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment, even if that refusal will lead to their death. The bill does not require a patient to undergo treatment that will prolong their life or that might cure them, because to do so would cut across the fundamental principle of patient autonomy.

Hon MICHAEL MISCHIN: That response surprises me because we are told that this is implicit in other criteria in the legislation. I would like that to be pointed out to me. I also refer to the second reading speech, and get back to what is and is not suicide. In introducing the bill, the minister stated —

> It would be wrong to confuse voluntary assisted dying with suicide. The bill specifically provides that voluntary assisted death is not suicide. Suicide involves the tragic loss of life of a person who is otherwise not dying. Voluntary assisted dying involves a person's choice about the manner of their death when faced with inevitable and imminent death as a result of an incurable disease, illness or medical condition.

Now we are being told that that is going to be far too restrictive, so I would like to have that explained.

Hon STEPHEN DAWSON: The notion of incurability is implicit in clause 15, which refers to the illness being advanced and progressive and that it will, on the balance of probabilities, cause death. If we were to include "incurable", as Hon Nick Goiran is seeking to do through his amendment, then, for example, should there be some sort of treatment available in some far-flung place around the world, this amendment could lead to the patient needing to travel overseas at great expense and difficulty, and potentially while very ill, to access the treatment. The bill does not require that the condition be incurable. What was meant in the second reading speech is that the patient has a terminal condition. I would not wish to say that a patient "must" get medical treatment.

Hon MICHAEL MISCHIN: So the government's endorsement last week of the second reading speech, after I asked whether the government stood by it, remains, but we are not to read the second reading speech literally. Never mind about a patient who has to travel to the wilds of Tibet in order to obtain a cure for a condition; let us say there is one just around the corner. I have a disease, illness or medical condition that is advanced, progressive and will, on the balance of probabilities, cause death within six months. I am suffering discomfort or pain to the point at which I think it is intolerable. If I avail myself of treatment by going over to an appropriate specialist, I could be cured of the condition, but I just do not want to because I have gone to a doctor who specialises in my illness and has informed me that the option of voluntary assisted dying is available, and all my problems will be over. I will not have to suffer discomfort, pain and other inconveniences. Are we not throwing the net much wider than even the second reading speech policy contemplated and urged us to accept as one of the narrow confines within which this particular remedy would be available to patients? It seems to me that the amendment that has been suggested is entirely consistent with the policy of the bill as articulated by the government in the other place, and in here. Forget about my having to go halfway around the world—what if I am in the position that I have simply outlined and I say, "I'm just not interested in getting treatment"?

Hon STEPHEN DAWSON: It is always a question for the patient. It is unlikely that a patient who has access to an easy treatment that will not harm them will decide not to take it. As I have said previously, every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment even if that refusal will lead to their death.

Hon MICHAEL MISCHIN: So voluntary assisted dying is now a treatment option? Is the minister saying that we should not make it too restrictive; that is, rather than having a state-sanctioned means of terminating someone's life in restricted and narrow circumstances, cases of extreme suffering, with no prospect of living a life of any sort of quality, we are now throwing it open to a treatment option that the patient can accept or refuse, and then go to a doctor, tick the criteria, and have a state-sanctioned death, either by self-termination or through the agency of a medical practitioner? Is that what we have got to?

Hon STEPHEN DAWSON: No. Voluntary assisted dying is an option. It is not a medical treatment. I am saying that accessing voluntary assisted dying is not contingent on a patient first getting treatment.

Hon NICK GOIRAN: Is it the government's intention that a patient with type 1 diabetes who does not take their medication should have access to voluntary assisted dying?

Hon STEPHEN DAWSON: It is not for the government to speculate about a decision that a medical practitioner might make in the future. There will be an independent assessment on a case-by-case basis as per the eligibility criteria. Each individual is able to exercise their right to accept or to refuse medical treatment. This is self-autonomy.

Hon NICK GOIRAN: If a Western Australian breaks their arm and goes to see a medical practitioner, a lack of treatment as a result of that will not lead to the death of the person. A person will not become terminally ill because they break their arm. So when the minister says that he will not speculate, I think that, as serious lawmakers, we can speculate and come to the conclusion that a Western Australian who breaks their arm will not be able to access voluntary assisted dying, because a broken arm will not qualify as an advanced progressive condition that will cause their death. I want to contrast the broken arm scenario with a Western Australian with type 1 diabetes who ceases to take their insulin. On the expert advice that has been provided to me, I am told that that person would become terminally ill, because they would develop diabetic ketoacidosis, which, left untreated, would lead to diabetic coma and death. It troubles me that we are opening the door for that scenario. I would like confirmation from the government that that is not its intention—it does not want to see Western Australians with type 1 diabetes cease to take their insulin and access this as an option.

Hon STEPHEN DAWSON: Of course we do not want to see people with type 1 diabetes accessing voluntary assisted dying. One would hope that such a person would access available medical treatments. I again say that I do not want to speculate about a decision that a medical practitioner might make in the future, because this will be an independent assessment on a case-by-case basis, as per the eligibility criteria in the bill.

Hon MICHAEL MISCHIN: I am exploring this rather than having had the opportunity to think it through, but perhaps rather than "incurable" in the second reading speech, what was meant in the speech was "not treatable with any reasonable prospect of cure or improvement" or "not being reasonably treatable with a prospect of cure or improvement" or some formulation to that effect. Is that what the government was driving at by saying "incurable"? If that is the case, it seems to me that an appropriately crafted amendment might fix some of the difficulties we have identified.

Hon STEPHEN DAWSON: I think the government's intention is clear in the clauses of the bill, as set out before us. Honourable member, with the greatest respect, I am not going to go back to the second reading speech—the time to question that has passed. We are dealing with the amendment moved by Hon Nick Goiran at clause 15. I have indicated that we are not supportive of the amendment.

Hon NICK GOIRAN: Is it the minister's intention to correct the statement that he made in the second reading speech, when he said —

> Voluntary assisted dying involves a person's choice about the manner of their death when faced with inevitable and imminent death as a result of an incurable disease, illness or medical condition.

Does the minister intend to correct the record or leave it in that state?

Hon STEPHEN DAWSON: I am happy to state now that what I meant in the second reading speech was that it is terminal. That was my intention, and I make that clear to the house.

Hon MARTIN PRITCHARD: I do not want to participate too much in the debate, but treating type 1 diabetes does not actually cure it; it treats it and keeps it managed. It is a bit of a misleading point.

Hon NICK GOIRAN: I will just wrap up on this point. Member, is that not the point, that a person with diabetes can take insulin? I understand that the member is saying that there is perhaps a distinction. I think that is what Hon Michael Mischin was referring to—whether we are talking about something being untreatable or incurable. I think the point the member made is a good one. In that sense, diabetes is not able to be cured but it is able to be treated, and it is not treatment that people would describe as futile. It is a principle in common law, if not in statutory law in Western Australia—I would have to check—that a person has the right to refuse medical treatment. I am pretty sure that doctors have a statutory right—they certainly have the right at common law—to refuse to provide futile medical treatment. The government said, in its own second reading speech, that this bill is supposed to deal with incurable situations. It is no wonder the member for Girrawheen in the other place moved an amendment relating to circumstances in which that exact language is used in the Victorian legislation. For the government to say now, at the eleventh hour, that it did not really mean "incurable" is not a particularly satisfying response.

Hon CHARLES SMITH: I draw the minister's attention to subclause (1)(e). Short of someone saying it explicitly, how would coercion realistically be detected under this bill?

The DEPUTY CHAIR: Member, we are dealing with the matter before us at the moment, which is the amendment moved by Hon Nick Goiran. We will deal with that and then we will move on. The question is that the words to be inserted be inserted.

Division

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

Ayes (11)

Hon Peter Collier	Hon Nick Goiran	Hon Simon O'Brien	Hon Colin Tincknell
Hon Donna Faragher	Hon Rick Mazza	Hon Robin Scott	Hon Ken Baston *(Teller)*
Hon Adele Farina	Hon Michael Mischin	Hon Charles Smith	

Noes (22)

Hon Martin Aldridge	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Dr Sally Talbot
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Darren West
Hon Robin Chapple	Hon Sue Ellery	Hon Martin Pritchard	Hon Alison Xamon
Hon Jim Chown	Hon Diane Evers	Hon Samantha Rowe	Hon Pierre Yang *(Teller)*
Hon Tim Clifford	Hon Laurie Graham	Hon Aaron Stonehouse	
Hon Alanna Clohesy	Hon Colin Holt	Hon Matthew Swinbourn	

Amendment thus negatived.

Hon ADELE FARINA: I would like some clarification on this clause and, in particular, subclause (1)(c), which refers to —

> the person is diagnosed with at least 1 disease, illness or medical condition that —
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> …
>
> (iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

My understanding is that the person needs to be assessed as meeting the eligibility criteria at the time of making the request to access voluntary assisted dying. In the debate on this issue of the eligibility criteria, a number of people have indicated that, under this legislation, it is quite appropriate for people to obtain access to voluntary assisted dying before their suffering is intolerable on the basis that they will then be able to administer the drug at the point at which the suffering becomes intolerable. I would like some clarification, because my reading of this provision is that the suffering needs to be such that it cannot be relieved in a manner that the person considers tolerable at the time that the request is made and the assessment is made in order to meet the eligibility criteria. If the suffering is tolerable at that time, the person does not meet the eligibility criteria. I would like some clarification on that.

Hon STEPHEN DAWSON: When the person is assessed, they must meet all the eligibility criteria, including clause 15(1)(c)(iii).

Hon ADELE FARINA: Just to put that beyond doubt, at the time that someone makes the first request to seek access to voluntary assisted dying and they are assessed, the suffering that they are experiencing must be of the nature that the person considers intolerable.

Hon STEPHEN DAWSON: That is correct. It is when they are assessed. It is not at first request, but when they are assessed.

Hon ADELE FARINA: I now go to clause 15(1)(f), which requires that "the person's request for access to voluntary assisted dying is enduring". I do not know how the practitioner can assess whether that eligibility criterion is met on the first assessment, because the first assessment will follow the first request. It will be the first time a person has requested access to voluntary assisted dying. I do not know the basis on which we would assess whether that request is enduring. It seems to me that if that criterion were left in the eligibility criteria for the first assessment, every assessment would have to fail because there would be no way to establish that the person's request for access to voluntary assisted dying is enduring.

Hon STEPHEN DAWSON: Endurance is demonstrated from the time of the first request. After that, endurance is assessed at several stages. The enduring nature of the request must be considered and demonstrated repeatedly throughout the process—that is, at the first request, at the written declaration, at the final request, at the final

review, at the time of the administration decision, at the time of dispensing and at the time of administration if it is practitioner administered.

Hon ADELE FARINA: I turn the minister's attention to clause 23, which reads —

> (1) The coordinating practitioner for a patient must assess whether the patient is eligible for access to voluntary assisted dying.
>
> (2) For the purposes of subsection (1), the coordinating practitioner must make a decision in respect of each of the eligibility criteria.

On the first assessment, the coordinating practitioner needs to make a decision on the person's request for access to voluntary assisted dying being enduring. Could the minister explain to me how the coordinating practitioner makes that assessment and decides that the eligibility criteria have been met on the first assessment?

Hon STEPHEN DAWSON: Endurance is assessed between the time of the first request and when the actual first assessment takes place; so this may be some time later.

Hon ADELE FARINA: It is also possible, is it not, for the assessment to be made at the same time that the request is made? The request needs to be made in a consultation, so there is no reason why that assessment could not be made during the course of that consultation, when that request is first made.

Hon STEPHEN DAWSON: As part of the assessment, the medical practitioner will be exploring the reasons why the patient wants to access voluntary assisted dying. If the medical practitioner has questions about the enduring nature of the request, they could make a finding that the patient is ineligible or does not meet the eligibility criteria.

Hon ADELE FARINA: With all due respect, I do not think the minister really answered my question. The question I asked was: how does a medical practitioner make an assessment on the first assessment that the eligibility criteria in clause 15(1)(f) has been met? The patient may have just received their diagnosis and prognosis and may be discussing treatment options, and the patient may say, "I want to put in a request now for voluntary assisted dying." How does the doctor in those circumstances make a decision about whether the person's request to access voluntary assisted dying is enduring? On any reasonable assessment of this, that criteria cannot be met on the first assessment. Keeping it in the eligibility criteria for the first assessment is actually creating a fundamental problem with this bill. It suggests that the eligibility criteria have no value at all because the criteria at paragraph (f) cannot be met on the first assessment, yet it is required under this bill that the medical practitioner be satisfied that it has been met. I would like an explanation about how the medical practitioner makes an assessment on the first assessment that the person has met the eligibility criteria that their access to voluntary assisted dying is enduring.

Hon STEPHEN DAWSON: The medical practitioner would use multiple ways to support a decision about a criterion—for example, discussion with the patient about their medical history and social history, and their perspectives on voluntary assisted dying. They would know when the diagnosis had been made, and clearly, if it was a while ago, the patient has had time to consider. If, at that very moment, they have not, the medical practitioner may determine that it is not enduring. In all scenarios the eligibility can be assessed. There may be a case, such as that described by Hon Adele Farina, in which a patient has just been diagnosed and then makes the first request, and then the first assessment takes place. Then the medical practitioner may say that the patient does not meet clause 15(1)(f). As such, at this stage, the patient may not meet the criterion at clause 15(1)(f).

Hon CHARLES SMITH: Clause 15(1)(e) states that a person must be acting voluntarily and without coercion. Short of someone saying it to the practitioner, under this bill, how would coercion realistically be detected?

Hon STEPHEN DAWSON: General practitioners are well placed to identify patients at risk of experiencing elder abuse. There are clinical screening tools suitable for use with older people that can be readily incorporated into assessment procedures, and this would form part of the mandatory training. The assessing medical practitioners will be required to assess whether a patient is acting voluntarily and without coercion. Furthermore, they may refer the assessment to a practitioner skilled in this area if they are of the opinion that they cannot make an accurate assessment themselves. They may also refer the matter to existing authorities, such as the WA Police Force, if they believe that a patient is being coerced to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner.

Hon NICK GOIRAN: I have some concern about the line Hon Charles Smith has brought to our attention—that is, the criterion in clause 15(1)(e), which states that a person is acting voluntarily and without coercion. In the minister's second reading speech on 26 September, he stated —

> There have been numerous inquiries, both internationally and in Australia, that have considered the issue of coercion. These inquiries concluded that there is no evidence that the vulnerable are being coerced into accessing voluntary assisted dying.

That being the case, why was it deemed appropriate to include the eligibility criterion in clause 15(1)(e)?

Hon STEPHEN DAWSON: It has been included to be clear that a patient must be free of coercion and must be acting voluntarily. It is a fundamental concept for voluntary assisted dying.

Hon NICK GOIRAN: In the second reading speech, the minister referred to numerous inquiries, both internationally and in Australia. Is he in a position to table any of those inquiries?

Hon STEPHEN DAWSON: I am not in a position to table information about those inquiries now. I am happy to take the question on notice, seek further information and hopefully provide it to the chamber at a later stage. Certainly, my advisers tell me that evidence from both Oregon and the Netherlands demonstrates that members of vulnerable groups 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.

Hon NICK GOIRAN: It is very interesting that the minister should refer to Oregon. I draw to his attention the "Oregon Death with Dignity Act: 2018 Data Summary", which indicates that burden on family, friends and caregivers was cited by more than half of the patients who died from ingesting a lethal dose of medication in Oregon in 2018. I look forward to the minister tabling those inquiries, which will substantiate the claim made in the second reading speech that there have been numerous inquiries, both internationally and in Australia, that have considered the issue of coercion and concluded that there is no evidence that the vulnerable have been coerced into accessing voluntary assisted dying. I particularly look forward to those inquiries being tabled, and the highlighting of the parts of the inquiries where the issue of coercion has been considered, and where the conclusion is drawn in those inquiries that there is no evidence. I look forward to that being tabled. While we are talking about matters that are to be tabled, the minister might recall that last week we discussed a document that might get tabled. Would this be a convenient time to deal with that issue?

Hon STEPHEN DAWSON: Although it is not related to clause 15, I did indicate to the honourable member last week that I would provide some further information about obligations on registered practitioners and penalties for contravention of the bill, so I am happy to table that document now.

[See paper 3435.]

Hon NICK GOIRAN: I am concerned about the eligibility criterion at clause 15(1)(e), which states that the person must be acting voluntarily and without coercion. I move —

> Page 12, line 21 — To delete "without coercion;" and substitute —
>
> not as a result of abuse, coercion, duress or undue influence;

The DEPUTY CHAIR (Hon Dr Steve Thomas): Do we have a written version of that? Honourable members, we are dealing with clause 15 and you should have before you the following amendment moved by Hon Nick Goiran —

> Page 12, line 21 — To delete "without coercion;" and substitute —
>
> not as a result of abuse, coercion, duress or undue influence;

The amended proposed subsection (e) would read —

> the person is acting voluntarily and not as a result of abuse, coercion, duress or undue influence;

Hon NICK GOIRAN: This amendment strengthens the principle of voluntariness, which underpins the entire Voluntary Assisted Dying Bill. Members will note that a person's request for access to voluntary assisted dying should not be impacted or influenced by coercion, as clause 15(1)(e) currently states. However, I trust that members would also agree with me that a person's request should not be impacted or influenced by any abuse, duress or undue influence. The inclusion of these terms in this clause serves only to strengthen the protections afforded to patients by this bill. It is not onerous and it is not complicated, nor does it radically change the operation of the bill. When assessing the eligibility of a person to access voluntary assisted dying, a coordinating and consulting practitioner should have regard to more than just the absence of coercion. I note that the inclusion of "abuse" is consistent with the use of the term "abuse" in clauses 4(1)(i) and 158(c) and the inclusion of the term "undue influence" is consistent with the use of that term in clauses 99(2) and 100.

Hon STEPHEN DAWSON: The government is not supportive of the amendment standing in the name of Hon Nick Goiran. The current wording makes it clear that the consideration is in relation to the person's action at the time of the assessment. We previously debated clause 4, "Principles", for which similar words were sought to be included. I outlined at that stage significant reasons why we did not support the changes. Essentially, we do not

wish to add unduly technical legalistic words that do not advance the broad effect of the provision as currently drafted, so we are not in support of it.

Hon NICK GOIRAN: The minister says it is unduly legalistic and technical, yet his own bill at clauses 99(2) and 100 use the words "undue influence". I do not see any amendment in the minister's name on the supplementary notice paper to indicate he is intending to delete those words from clauses 99 or 100. It seems to me that if it is good enough to use the phrase "undue influence" in clauses 99 and 100, it is good enough to use it in clause 15, given its significance, whereby we are saying to medical practitioners that we want them to assess a person against each and every one of the criteria. I draw to the minister's attention that in clause 4, "Principles", the chamber agreed—my recollection is that he agreed—to an amendment moved by Hon Martin Pritchard to include "coercion with abuse", so the terms are consistent with the language used in the bill and I seek the support of members accordingly.

Hon AARON STONEHOUSE: Just so that I have a clear understanding of what is sought to be changed, can the minister point me to what definition of "coercion" is being used for the purpose of this clause? A common understanding of coercion is the actual use of violence or the threat of violence to influence someone's decision. Is there a different definition used here that we can refer to in the Criminal Code or some other statute?

Hon STEPHEN DAWSON: First of all, clauses 99 and 100 are offence provisions. As I have previously indicated, "undue influence" is legalistic terminology that is reflected in the offence provisions of the bill. It is a legal term that is understood by the legal profession; however, it is less familiar to the general community. Clause 15 provides for criteria that are assessed by medical practitioners. With regard to Hon Aaron Stonehouse's question, in this case it is used to indicate voluntariness as a criterion of eligibility. The use of "coercion" and "abuse" in the principles is directed at protecting vulnerable persons. Under clause 15, "coercion" is used to underscore that a person's decision must be voluntary. The level of abuse required to frustrate the clause is built into "coercion".

Hon AARON STONEHOUSE: I am looking for a definition of "coercion" somewhere in Western Australian statutes, and I cannot really find one. There is "sexual coercion" under the Criminal Code, but it does not really go into detail about the coercion aspect. Instead, I am relying on a definition that is provided by the Department of Mines, Industry Regulation and Safety, which states —

> Coercion involves force (actual or threatened) that restricts another person's choice or freedom to act.

That is my understanding of coercion and I think it would be the common understanding of the word, but that implies force or violence; it does not cover abuse, which would capture more activity that might include physical injury or emotional or psychological harm. It is certainly true in other aspects of the law that when we talk about abuse, we cast a wider net. When we talk about things like domestic abuse, we do not limit it merely to violence or coercion; we also cover things like financial abuse, emotional abuse, psychological harm and things like that. When we talk about undue influence, there is certainly no violence involved there, so expanding clause 15 to include "abuse, coercion, duress or undue influence" would cover some of the ground that I think is missed by limiting it to merely "coercion". I suppose the word "voluntarily" in the requirement under clause 15(1)(e) that the person is acting voluntarily and without coercion would imply some of those things, but it would certainly do no harm to spell them out in clearer language. I reject the idea that "undue influence" is too legalistic. Throughout the course of this debate, that is a topic that has been touched upon quite a lot, and it is a pretty well understood concept in contract and common law. The only thing I am a little unsure of is the inclusion of "duress" in Hon Nick Goiran's amendment. I think that might be a bit redundant, as "duress" and "coercion" seem to overlap almost entirely. In any case, the inclusion of "abuse" and "undue influence" is, I think, absolutely necessary. We can discuss whether those are appropriate for inclusion in later clauses, keeping in mind that I do not think "coercion" covers abuse or undue influence. I think it is absolutely appropriate to include those terms in this clause, and therefore I support the amendment moved by Hon Nick Goiran.

Hon NICK GOIRAN: The other point I would make to members is that either we are going to get serious about elder abuse in our community or we are not. We had a select committee look into the prevalence of elder abuse in Western Australia, and here we have a situation in which at the end of life, a final decision is being made. Those members who are familiar with that committee's inquiries will know that there is an issue with the identification of elder abuse in our community, even by professionals. It is entirely appropriate that we make sure that this issue is top of mind for medical practitioners when assessing someone's eligibility to consider very clearly whether there is any undue influence, abuse, coercion or duress. I take the point made by Hon Aaron Stonehouse about the use of the word "duress". I have included it for the reason that, unlike the word "coercion", it appears in several of our Western Australian statutes, including the Adoption Act and the Surrogacy Act. The term "undue influence" appears later in this bill and in other statutes. Ironically, if any one of the three terms should not be there, it is probably

"coercion", which is in there anyway. It would certainly be consistent with good lawmaking practice to ensure that all these things have been captured, particularly in light of the recent inquiries into elder abuse.

Hon STEPHEN DAWSON: In answer to Hon Aaron Stonehouse's question about coercion, the ordinary dictionary meaning of "coercion" applies. Coercion is the practice of persuading someone to do something by use of dishonesty, force or threat. With regard to the issues around elder abuse, it is not the intent of this bill to address issues relating to aged care or quality of life in older Western Australians. The bill sets out to provide choice for a small number of people nearing the end of their life on the timing and manner of their death. The mandatory training required under this bill to be provided to medical practitioners will include the identification of risk factors for abuse. I have previously indicated the government's intentions in dealing with the issue of addressing elder abuse, including its prevention. I have made clear that we are not supportive of Hon Nick Goiran's amendments to this clause, for the reasons that I have previously outlined.

Hon AARON STONEHOUSE: I would like to make one final point. I appreciate that this bill is not intended to address elder abuse, but it should absolutely be at the front of everyone's mind as we progress through this debate. We should be doing whatever we can to mitigate those risks. In fact, the government has made great efforts in talking up whatever the quantum was of safeguards. We should do absolutely everything we can. We should be absolutely certain that we do whatever we can to mitigate whatever risks might be presented by the passage of this bill. I think that ensuring that "abuse" and "undue influence" are covered under clause 15(1)(e) would be one way of doing that. I encourage everyone who is paying attention to give this amendment some thorough thought and to pass it. It certainly would not diminish the bill in any way or make it any more onerous; it will just ensure that those extra acts are covered and spelt out in black and white, rather than relying on a dictionary interpretation of the word "coercion", which is not defined in statute elsewhere.

Division

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

Ayes (14)

Hon Jim Chown	Hon Simon O'Brien	Hon Charles Smith	Hon Alison Xamon
Hon Donna Faragher	Hon Martin Pritchard	Hon Aaron Stonehouse	Hon Nick Goiran *(Teller)*
Hon Adele Farina	Hon Robin Scott	Hon Dr Steve Thomas	
Hon Rick Mazza	Hon Tjorn Sibma	Hon Colin Tincknell	

Noes (21)

Hon Martin Aldridge	Hon Peter Collier	Hon Colin Holt	Hon Dr Sally Talbot
Hon Ken Baston	Hon Stephen Dawson	Hon Alannah MacTiernan	Hon Darren West
Hon Jacqui Boydell	Hon Colin de Grussa	Hon Kyle McGinn	Hon Pierre Yang *(Teller)*
Hon Robin Chapple	Hon Sue Ellery	Hon Michael Mischin	
Hon Tim Clifford	Hon Diane Evers	Hon Samantha Rowe	
Hon Alanna Clohesy	Hon Laurie Graham	Hon Matthew Swinbourn	

Amendment thus negatived.

Hon CHARLES SMITH: I move —

Page 12, after line 23 — To insert —

(g) the person has considered the impact that the person accessing voluntary assisted dying may have on the person's family.

Many residents of Western Australia have sent correspondence to many of us here. One of the concerns that was raised was how will family members know when a person has decided to access voluntary assisted dying. To that end, I want to add an additional eligibility criterion. This particular criterion comes from the Northern Territory Rights of the Terminally Ill Act, which seems to be a reasonable model that we can use. Section 7(1)(g) of that act states —

> the medical practitioner is satisfied that the patient has considered the possible implications of the patient's decision to his or her family;

As the bill is currently drafted, the patient's family may not be aware of the patient's voluntary assisted dying request until after the death of the patient. I hope members will agree that some people may end up with a nasty surprise if they were not expecting their relative to access voluntary assisted dying. Members may note that the amendment does not go so far as to mandate the request. It only asks the patient to confirm that they have considered the impact on their family of their accessing voluntary assisted dying. I think it is a reasonable amendment. It is a family-friendly

amendment. I would not like a person to suddenly find out that their mother, brother, sister or daughter has accessed voluntary assisted dying. I commend the amendment to members for their consideration.

Hon STEPHEN DAWSON: It will not surprise the honourable member that the government does not support this amendment. We do not believe this is an appropriate eligibility criterion. The underpinning principle of voluntary assisted dying is that the patient will make the decision themselves about whether they wish to access voluntary assisted dying. It is likely that a dying person will have considered the impact of their death on their friends and family. Furthermore, it is likely that the dying person will also have considered the impact based on the fact that their death will be brought about by their accessing voluntary assisted dying. However, to legislate for such a consideration would be an impingement on the patient's autonomy. Therefore, we do not support the amendment.

Hon RICK MAZZA: If someone accesses voluntary assisted dying, it will be a deeply personal decision. I do not know that requiring the person to consider their family in that case should be a test of whether they can or cannot access voluntary assisted dying. In fact, in some cases the person might not want anyone in their family to know about it. I would find it very difficult to support this amendment.

Hon ALISON XAMON: In an ideal world, when someone is facing imminent death, whether it be from their illness or because they access voluntary assisted dying, we would always hope that they would feel that they were able to reach out and get support from their loved ones, from family. However, I think it is a step too far to try to prescribe that desire within the legislation. Unfortunately, not everyone comes from a functional family. Sometimes, people are estranged, for good reason, from people who may feel that they have a vested interest in somebody else's life, but the person who is dying may not feel that that is appropriate. It may also be the case, as has already been mentioned, that a person may decide to not tell their family that they are dying. We may have opinions about that. We may look upon such a scenario with sadness and reflect on how unfortunate that may be for those individuals, but, nevertheless, that is that individual's choice. I do not think it is appropriate for us to try to prescribe within legislation the nature of family relationships.

Hon AARON STONEHOUSE: I have a question for the minister around this. I am leaning towards the position that was expressed by Hon Rick Mazza and Hon Alison Xamon in that it might be a step too far to prescribe this. However, can the minister advise me whether any consideration has been given to including in the training provided to medical practitioners how patients might discuss with their family their choice to access voluntary assisted dying, or their end-of-life choices, and whether those discussions are a healthy thing and whether they should be promoted or avoided? How might that fit into the scheme and the material or training that is provided and that will be prescribed in regulation? There is not much in the primary legislation that deals with family. Family is a very important institution in our society, and it should be preserved wherever possible, although I draw a line at prescribing it and having statutory obligations to family. In the development of the training material and the support that will be provided to medical practitioners that will be prescribed in regulation, what weight will be put on discussion with family? What promotion of discussion with family will be in the material that is provided to medical practitioners or patients?

Hon STEPHEN DAWSON: I am told that it is good clinical practice for practitioners to have those types of conversations with patients, so it is reasonable to think that that issue will be canvassed as part of the training that takes place. I think the likelihood is that medical practitioners will encourage people to have a conversation with wider family members if appropriate. As others have indicated, it is not always appropriate. It is a personal decision at the end of the day.

Hon NICK GOIRAN: Is the amendment that has been moved by Hon Charles Smith consistent or inconsistent with clause 4(1)(g)?

Hon STEPHEN DAWSON: Clause 4(1)(g) is a patient-centred principle. The amendment that stands in Hon Charles Smith's name is obviously very family focused.

Hon NICK GOIRAN: I will support the amendment moved by the honourable member because there is nothing in it that forces the patient to have any conversations with family members; it simply ensures that the doctor will ask whether the person has considered the impact of their decision on their family. I go back to the example that I gave the minister when we last had this debate. As a father of two teenage daughters, I am mindful that it is possible for an 18-year-old to access this regime without having had any conversation with their family. The amendment moved by Hon Charles Smith will not change that; an 18-year-old will still be able to access this regime without telling their family. However, the thing that I like about the amendment moved by the honourable member is that it will at least ensure that the doctor has some conversation with the patient, which is consistent with clause 4(1)(g), which states —

> a person should be supported in conversations with the person's health practitioners, family and carers and community about treatment and care preferences;

It will ensure that the practitioner has at least had a conversation with the patient about that. What the patient wants to do after all of that is, of course, entirely a matter for them.

Hon Alannah MacTiernan: It sounds like it is putting undue pressure on them, really.

Hon NICK GOIRAN: Hon Alannah MacTiernan should remember that she has no concerns about that, because she just voted against an amendment that would have ensured that an eligibility criteria was that a person was not under duress or undue influence. We already know her position on that. I obviously hold a very different position on that from Hon Alannah MacTiernan—I take the issue of influence very, very seriously. I think this amendment will ensure that a person has a conversation with at least a doctor about the impact on their family. For those reasons, I support the amendment.

Amendment put and negatived.

Clause put and passed.

Clause 16: Eligibility to act as coordinating practitioner or consulting practitioner —

Hon NICK GOIRAN: There are some amendments on the supplementary notice paper to clause 16, but before we get to those, I have a number of questions. I also note that the first amendment on the supplementary notice paper is in the name of Hon Colin Tincknell, and deals with page 14 after line 2. I have an amendment that precedes Hon Colin Tincknell's amendment, which I will deal with shortly. I should also indicate for the benefit of the clerks that the amendment standing in my name at 164/15 should remain on the supplementary notice paper because it is consequential on other matters.

Clause 16 sets out the eligibility criteria for a medical practitioner to be able to act as a coordinating practitioner or consulting practitioner. Would it be possible for the coordinating or consulting practitioner to be a family member of the patient?

Hon STEPHEN DAWSON: I am told that it is not considered appropriate under "Good Medical Practice: A Code of Conduct for Doctors in Australia". Paragraph 3.14 of that guide of the Medical Board of Australia deals with this issue.

Hon NICK GOIRAN: So it is not good practice, but under the bill that is before us, would it be possible for the doctor to be a family member of the patient?

Hon STEPHEN DAWSON: I am told that it is not contemplated under the bill. Certainly, clause 16(2) refers to meeting the requirements approved by the CEO for the purposes of each paragraph there. I am told that the issue would be dealt with during the implementation phase, but it is certainly not contemplated by government.

Hon NICK GOIRAN: Members, when the minister says that it is not contemplated in the bill, it means that the bill is silent on this issue. Would it be possible for the coordinating practitioner or the consulting practitioner to be a beneficiary under the will of the patient?

Hon STEPHEN DAWSON: Yes, it is.

Hon NICK GOIRAN: I ask the minister to turn to clause 160 of the bill, which sets out criteria that deal with interpreters. We will get to clause 160 in due course, but it states that the bill will allow for interpreters to be used, which we discussed a bit under clause 1. I ask the minister to look specifically at clause 160(2), which states —

> An interpreter for a patient —
>
> …
>
> (b) must not —
>
> (i) be a family member of the patient; or
>
> (ii) know or believe that they are a beneficiary under a will of the patient or that they may otherwise benefit financially or in any other material way from the death of the patient …

Why is it appropriate that we provide these prohibitions for interpreters, but not for medical practitioners?

Hon STEPHEN DAWSON: We do not believe that it is necessary because medical practitioners are bound by their professional code of practice.

Hon NICK GOIRAN: I move —

> Page 13, line 19, to page 14, line 5 — To delete the lines and substitute —
>
> (2) A medical practitioner is eligible to act as a coordinating practitioner for a patient if —
>
> (a) the medical practitioner —

(i) holds specialist registration, has practised the medical profession for at least 1 year as the holder of specialist registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

(ii) holds general registration, has practised the medical profession for at least 10 years as the holder of general registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

(iii) is an overseas-trained specialist who holds limited registration or provisional registration and meets the requirements approved by the CEO for the purposes of this subparagraph;

and

(b) the medical practitioner is not a family member of the patient; and

(c) the medical practitioner does not know or believe that the practitioner —

(i) is a beneficiary under a will of the patient; or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the coordinating practitioner for the patient.

(3) A medical practitioner is eligible to act as a consulting practitioner for a patient if —

(a) the medical practitioner —

(i) holds specialist registration, has practised the medical profession for at least 1 year as the holder of specialist registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

(ii) holds general registration, has practised the medical profession for at least 10 years as the holder of general registration and meets the requirements approved by the CEO for the purposes of this subparagraph; or

(iii) is an overseas-trained specialist who holds limited registration or provisional registration and meets the requirements approved by the CEO for the purposes of this subparagraph;

and

(b) the medical practitioner is not a family member of —

(i) the patient; or

(ii) the coordinating practitioner for the patient;

and

(c) the medical practitioner does not know or believe that the practitioner —

(i) is a beneficiary under a will of the patient; or

(ii) may otherwise benefit financially or in any other material way from the death of the patient, other than by receiving reasonable fees for the provision of services as the consulting practitioner for the patient;

and

(d) the medical practitioner —

(i) does not own a health facility or medical facility with the coordinating practitioner for the patient; and

(ii) is not a supervisor of, or supervised by, the coordinating practitioner for the patient at a health facility or medical facility; and

(iii) is not employed or engaged under a contract for services, or a consultant, at a health facility or medical facility where the coordinating practitioner for the patient is also employed or engaged or a consultant.

(4) The CEO must publish the requirements approved for the purposes of subsections (2)(a)(i), (ii) and (iii) and (3)(a)(i), (ii) and (iii) on the Department's website.

(5) In this section ***medical facility*** means a medical centre, medical clinic or similar facility.

The DEPUTY CHAIR (Hon Adele Farina): Members, Hon Nick Goiran has moved an extensive amendment. I think we will just take a short hold while we wait for copies of that amendment to be distributed so that members can read the amendment and understand what is currently being considered by the chamber.

Hon ALISON XAMON: Can I quickly ask a question to the member who moved the amendment?

Hon STEPHEN DAWSON: Can we wait until we have a copy of it? I would love to be able to follow the member's question, but until I have a copy of it, it is difficult.

Hon ALISON XAMON: It is about the form of the amendment, not the substance.

The DEPUTY CHAIR: Hon Alison Xamon, the minister has indicated that it would help him to follow the discussion if he has a copy of the amendment before him and I think that is a reasonable position to hold, so I think we will just hold for a few minutes while we wait for that amendment to be distributed to members.

Can members indicate whether they are happy to continue at this point with consideration of the amendment? There has been an opportunity to peruse the lengthy amendment.

Hon ALISON XAMON: We have, of course, the quite comprehensive amendment in front of us. I note that the amendment effectively has two different intents enshrined within the one amendment. The second intent is to make sure that the medical practitioner does not have any sort of conflict of interest or any sort of capacity to benefit from a patient's death. It strikes me that that is an eminently sound and important provision that is probably worthy of inclusion within the bill. I think that would improve the bill in its current form. I am interested that two different components have been coupled into the one amendment. My question to the minister is specifically about the provisions as outlined in clause 16(2)(a), which prescribes the professional requirements of a medical practitioner, and their eligibility. Looking only at the provisions within subclause (2)(a), are they already implied within the bill or will this in any way limit the current provisions within the bill?

Hon NICK GOIRAN: As the author of the amendment—with the benefit of parliamentary counsel, I should add—I can perhaps assist by drawing to members' attention that clause 16(2) at page 13 of the bill sets out those professional requirements. The provision that the member has referred to in my amendment at clause 16(2)(a) is identical to that at page 13 of the bill; it is simply the numbering that is different. Subclause (2)(a)(i) refers to holding specialist registration, which is the same as subclause (2)(a) in the bill. My subclause (2)(a)(ii) equates to subclause (2)(b) in the bill; and my subclause (2)(a)(iii) equates to subclause (2)(c) in the bill.

Hon ALISON XAMON: I thank the mover of the amendment. That is very helpful because, obviously, we have only just seen this. Can I please confirm with the mover of the motion that the effect of the amendment is entirely about ensuring there will be no conflict of interest from any practitioner who is assisting a person seeking access to voluntary assisted dying?

Hon NICK GOIRAN: The answer to that is yes, and it is done in two ways: one way is that there is no conflict between the practitioner and the patient; the second way it is dealt with is to make sure there is no conflict between the two practitioners involved—the consulting practitioner and the coordinating practitioner. That is why, for example, members will see the suggestion in my amendment at clause 16(3)(b)(ii) that the medical practitioner is the consulting practitioner—that is, the second practitioner involved—and they also should not be a family member of the coordinating practitioner. There should be no family relationship with the patient nor between the two doctors.

Hon COLIN HOLT: While the minister is considering his answer, I wonder whether the mover of the motion can define "family member" and how far it goes in that consideration?

Hon NICK GOIRAN: I draw to the honourable member's attention clause 160(2)(b)(i) where the phrase "a family member" is used by the government in its bill, and so the same interpretation will apply. Whatever "family member" is intended to mean by the government with regard to interpreters will also apply to medical practitioners.

The DEPUTY CHAIR: I can add further clarification to that. There is a definition of "family member" at clause 5 of the bill.

Hon AARON STONEHOUSE: I thought I might as well take this opportunity to put my thoughts on the record. It seems an eminently sensible amendment put forward by Hon Nick Goiran. The policy intent of this amendment is something that everyone should agree with, regardless of their views on the policy of the bill at large. The intent of this amendment is to ensure there is no conflict of interest between medical practitioners, consulting or coordinating, or between a medical practitioner and a patient. It is something that I am certain everyone would agree with, if they understand properly what is being proposed. The question becomes, I think, whether or not such a prohibition already exists in the bill, whether implied or actual. If such a prohibition were implied, I think we would be on safer ground if we agreed to the amendment to at least spell it out clearly in black and white in the statute. I would rather not rely on implications or the penumbra of what the legislation says when we are putting in place safeguards to protect vulnerable people. If such a prohibition exists in the bill, that is good, because I would certainly be relieved to know

that the government has not overlooked such a prohibition. But it would have to be explained by the minister where that prohibition exists in the bill. I would not want to rely on a prohibition existing somewhere else in some code of conduct or in some best clinical practice because I do not think that is sufficient in this case. We are discussing the contents of this bill and how this regime will be carried out. A code of conduct can always be changed and best clinical practice can also be changed over time. I think we should really be confident that the clauses of this bill that we agree to will provide adequate safeguards and not some other instrument that we have no control over here. With that, I absolutely support the amendment, but I look forward to hearing the minister's response.

Hon STEPHEN DAWSON: I am going to ask you to leave the chair until the ringing of the bells, Madam Deputy Chair. I need to take further advice on the amendment, and what the practical implications will be. For example, I can see that proposed clause 16(3)(d) of Hon Nick Goiran's amendment will cause issues for regional Western Australia. I ask you to leave the chair until the ringing of the bells, so that I can seek further advice to give the chamber a proper answer on this.

The DEPUTY CHAIR: The minister has asked me to leave the chair until the ringing of the bells, to seek further advice. I think that is eminently sensible, so I shall do so.

Committee interrupted, pursuant to standing orders.

[Continued on page 9220.]

Sitting suspended from 4.01 to 4.30 pm