

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Martin Aldridge) in the chair; Hon Stephen Dawson (Minister for Environment) in charge of the bill.

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

Committee was interrupted after the amendment moved by Hon Nick Goiran had been partly considered.

Hon STEPHEN DAWSON: Advice is being handed to me now, so I am digesting it as we progress. We are not supportive of the amendment that stands in Hon Nick Goiran's name. However, the government is amenable to the concept that a coordinating or consulting practitioner not be a family member of the patient or a beneficiary of their will. We do not accept the amendment as drafted and have drafted an alternative amendment. Furthermore, we reject the inclusion of the subclause that sets out the relationship between the coordinating practitioner—that is, Hon Nick Goiran's proposed new clause 16(3)(d). We believe that paragraph (d) would seriously frustrate the operation of the bill, particularly in regional and remote areas. Noting that some practitioners work in both the private and public space and in more than one hospital, it could effectively reduce the number of practitioners who could act as a coordinating or consulting practitioner. Proposed new clause 16(3)(d) is not consistent with the intent of the new principle in clause 4(1)(ha) regarding regional areas. That principle is worth repeating for the benefit of honourable members, and I quote —

a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and palliative care as a person who lives in the metropolitan region.

Furthermore, logically, a practitioner may be unaware in what capacity the other practitioner is employed or engaged.

Hon ROBIN CHAPPLE: This amendment rolled up fairly quickly; it was not even on supplementary notice paper issue 10. When an amendment like this is introduced, we should expect the chamber to address it in detail because it is fairly complex. There are elements of this amendment that are relatively good and elements that are ridiculous. It has been typed out, so this is not a spur-of-the-moment amendment. It should have been on the supplementary notice paper so that we could all deal with the matter in advance. I wonder how many more of these amendments Hon Nick Goiran has got up his sleeve.

Hon RICK MAZZA: I rise to say that I will support this amendment by Hon Nick Goiran. I am quite amazed that the bill does not provide that there should be no conflict between a medical practitioner and the patient, in the sense that the medical practitioner should not be a beneficiary of a will or a family member of the patient. I think, overall, this amendment will provide some integrity to the bill. I am quite surprised the government did not see that previously. The government has always said that this bill has many safeguards that make the process relatively safe. Not having this conflict issue embedded in the bill is an oversight or an omission. I will certainly be supporting the amendment in the form that has been put forward by Hon Nick Goiran.

Hon ADELE FARINA: I, too, think that there is a lot of merit to this amendment and that it is worthy of support. However, I also agree with the concerns expressed by the minister about paragraph (d) and how this might limit access to voluntary assisted dying in regional WA. Therefore, I intend to move an amendment to Hon Nick Goiran's amendment. I move —

To delete —

subclauses (3)(d) and (5)

This should take care of the minister's concern about the impact it might have in regional WA. It then strips it right back to the basics; that is, to ensure that there is no conflict of interest in the relationship between the medical practitioner and the patient.

Hon PETER COLLIER: Are we waiting for the minister's amendment?

Hon Stephen Dawson: No. We are waiting for Hon Adele Farina's amendment.

Hon PETER COLLIER: Hon Adele Farina is moving to delete proposed subclause (3)(d); is that correct?

Hon ADELE FARINA: I have moved to delete subclauses (3)(d) and (5). Subclause (5) provides a definition of a term that is used in subclause (3)(d), so I think we can get rid of both those. The minister did mention that the government might be moving an amendment, but I have not seen it.

Hon PETER COLLIER: That is what I want clarification on. I am receptive to this amendment, I have to say, particularly if we remove paragraph (d). It is up to the mover of the amendment, but I can understand why we would remove paragraph (d), particularly because of the implications it would have in some regional centres. I just want clarification on whether the minister intends to move his own amendment to this clause.

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Hon NICK GOIRAN: By way of explanation, I understand the rationale behind the amendment to the amendment moved by my learned friend Hon Adele Farina. I indicate that I am not supportive of the amendment to the amendment because my desire to have paragraph (d) in the amendment is to stop what I see as two practitioners setting up shop together and effectively providing a clinic throughout Western Australia. That, to me, would undermine the independence of the practitioners. People referring constantly to each other and saying, “I’ll be the consulting practitioner; you be the coordinating one”, does not fill me with confidence. That is the reason I oppose the amendment to the amendment. I also recognise that it is unlikely that the will of the chamber is to defeat the amendment to the amendment. I acknowledge that the will of the chamber is what it is.

Hon STEPHEN DAWSON: I indicated—I know that the Leader of the Opposition was away from the chamber on urgent business at the time—that the government is amenable to the concept that a coordinating or consulting practitioner not be a family member of the patient or a beneficiary of a will, but we do not accept the amendment and we have drafted an alternative amendment.

I also indicate that although we support the intent of Hon Adele Farina’s amendment to the amendment—it is certainly consistent with the government’s view—it is our belief that it could be drafted better. We have drafted an amendment and can move that, but I seek your advice, Mr Deputy Chair.

The DEPUTY CHAIR: What are you seeking?

Hon STEPHEN DAWSON: I am seeking your advice.

Hon Aaron Stonehouse interjected.

Hon STEPHEN DAWSON: I am happy to provide it. Everybody will get a copy before we debate it. Do we have to vote down both the amendment to the amendment and the amendment before I move my amendment?

The DEPUTY CHAIR: There are other ways of dealing with this. The issue we have, minister, is that we are dealing with a number of amendments of which none have been given notice on the supplementary notice paper, including your intention to move one. One way to resolve this is for you to circulate your amendment. The attendants can photocopy it and circulate it so that members can at least consider your amendment in the context of the amendment and the amendment to the amendment that are before the chamber. Essentially, minister, you are correct in that the amendment to the amendment and the amendment would need to be defeated so that you could then move your amendment.

Hon STEPHEN DAWSON: I am happy to circulate my proposed amendment so that members can consider all three.

Point of Order

Hon MARTIN PRITCHARD: I seek clarification. You mentioned, Deputy Chair, that the amendment to the amendment and the amendment have to be defeated. My understanding is that we would not necessarily have to defeat the amendment to the amendment, so long as the amendment was defeated. Am I correct in saying that?

The DEPUTY CHAIR (Hon Martin Aldridge): Hon Martin Pritchard, on your point of clarification, it would depend entirely on what the minister intends to move—whether that is an amendment to the substantive clause 16, or an amendment to the amendment of Hon Nick Goiran or, indeed, an amendment to the amendment of Hon Adele Farina. When that is circulated to the chamber, we will be in a better position to advise on the way forward.

Committee Resumed

Hon STEPHEN DAWSON: The amendment is being photocopied now. I can indicate that my amendment is to the substantive clause. It does not seek to amend Hon Nick Goiran’s amendment. I can further say that the difference between what will be circulated in my name and Hon Adele Farina’s amendment to the amendment is the split between coordinating and consulting practitioner into two subclauses. Hon Nick Goiran’s motion seeks to split those two; in mine, I have not. I do not believe it is necessary as the eligibility criteria for both is the same. That is the difference. The amendment is being circulated so people can consider it.

Hon NICK GOIRAN: To be clear, so that everyone understands—I have copped a fair amount of criticism over the course of this journey; some people will say rightly and others will say wrongly—the minister is suggesting that we spend a bit of time debating this and defeating the proposal by Hon Adele Farina, which, as I understand it, will substantively ensure that my amendment is the same as the minister’s, other than some formatting issues, and the minister would rather us spend time doing that and then deal with his amendment. Does the minister think that would be a good use of the time? I just want to make sure that we are all on the same page and we understand what is happening here.

Hon STEPHEN DAWSON: Just to be clear, I do not know whether the honourable member is trying to be smart. Certainly, the way I have worked throughout this debate has been to listen to those issues that have been raised by

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honourable members and to consider amendments as they have been raised and, if they do not destroy the intent of the bill, to take those issues on board when appropriate. That is what I have done so far and that remains what I will do as we continue through the passage of this bill. I am not supportive of Hon Nick Goiran's amendment, for the reasons I have indicated. I have also indicated that what will be circulated in my name is, my advisers tell me, a better way of putting our intention than the amendment to the amendment in Hon Adele Farina's name. People can play politics all they want. I am trying to make sure that we have a good bill and I am trying to ensure that I am taking on board the issues that are raised by honourable members as they are raised.

The DEPUTY CHAIR: Members, we are dealing with the amendment to the amendment moved by Hon Adele Farina. The question is that the words to be deleted be deleted.

Hon ROBIN CHAPPLE: Again, I raise the point that we are dealing with issues that can be resolved if we can see the minister's amendment. I am not saying that the minister is at fault in this, but rather than dealing with things through the supplementary notice paper, we are dealing with them on the fly, and I do not think that is a good way to operate in a house of review.

The DEPUTY CHAIR: Members, I have given you a few moments to consider the document that has been circulated throughout the chamber by the attendants. The document foreshadows the intent of the Minister for Environment representing the Minister for Health to move an alternative amendment to clause 16. That will give members some guidance as to the minister's intent once the question before the chamber is resolved. That question is, of course, the amendment of Hon Adele Farina to Hon Nick Goiran's amendment to clause 16, to delete subclauses 3(d) and (5). The question remains that the words to be deleted be deleted.

Hon AARON STONEHOUSE: Comparing the two substantive amendments, obviously what is absent from the minister's proposed amendment is anything dealing with the relationship between a consulting and coordinating practitioner. That is certainly the intention of the minister, although it leaves me a little concerned that there is nothing remaining in the bill or in the amendment we are likely to consider in a moment that would address that relationship and any conflicts of interest in that relationship. I appreciate what Hon Adele Farina has moved in trying to remove a roadblock for regional Western Australians accessing voluntary assisted dying that rules large sectors of medical practitioners ineligible to participate in this regime. It puts me in a difficult position in which I have two extremes. I have the option of the proposed amendment to the amendment, which would in no way regulate the relationship between coordinating and consulting practitioners; or I have the amendment proposed by Hon Nick Goiran which, on the face of it, does seem to go a little too far when we consider, as the minister pointed out, that there may be medical practitioners who work across the private and public sector and may have these relationships that are not necessarily a conflict of interest but will arise due to the nature of country health practice. It is difficult when faced with these two choices. I would much rather have seen an alternative to paragraph (d) that would regulate, but not in a way that was too exclusionary for medical practitioners in the regions. I just point that out. I suppose it will be the will of the chamber whether we agree to the amendment to the amendment and then the substantive amendment after that, but it seems like we have two extremes here and not really an ideal middle place that leaves me comfortable that those relationships between consulting and coordinating practitioners will be regulated appropriately to mitigate risk without excluding too many practitioners or patients.

Hon NICK GOIRAN: I take the point raised by Hon Aaron Stonehouse and I think that perhaps it would be addressed by the deletion of paragraph (d)(iii). The question that is currently before the chair is the deletion of the entirety of subclause 3(d), but I wonder whether removing paragraph (d)(iii) would address the member's concern, because it talks about whether somebody is under contract with another practitioner in the same sort of employment context, whether it be a health facility or medical facility. I would like to think that there would be some general agreement that proposed subclause (3)(d)(i) would be appropriate—that two medical practitioners who own a health facility or medical facility together should not be in cahoots or working in concert with regard to voluntary assisted dying. That is precisely the type of thing that I am concerned about.

If, for example, the infamous Dr Nitschke were to set up shop in Western Australia with another practitioner—there would be reasons why this might not happen, including that I am not sure whether he has medical registration anymore—and they were to call themselves the “WA One-stop VAD Shop”, I would find that distasteful. I would not want to see that happen here and I do not get the sense from other members that they want to see that happen either. Those who want to see this legislation pass are talking about an independent assessment done by one doctor and a referral to another doctor who does another independent assessment. I do not hear from members that we are talking about a one-stop shop. If the honourable member were to think that a one-stop shop is appropriate, they would want to see the entirety of proposed paragraph (d) defeated, but I wonder whether proposed paragraph (d)(iii) is the part that troubles the member.

Amendment on the amendment put and negatived.

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The DEPUTY CHAIR: Members, we now return to the amendment moved by Hon Nick Goiran, which is to insert certain words at page 13, line 19 to page 14, line 5. The question is that the amendment be agreed to.

Division

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

Ayes (14)

Hon Jim Chown
Hon Peter Collier
Hon Donna Faragher
Hon Nick Goiran

Hon Rick Mazza
Hon Michael Mischin
Hon Simon O'Brien
Hon Robin Scott

Hon Tjorn Sibma
Hon Charles Smith
Hon Aaron Stonehouse
Hon Dr Steve Thomas

Hon Colin Tincknell
Hon Ken Baston (*Teller*)

Noes (20)

Hon Martin Aldridge
Hon Jacqui Boydell
Hon Robin Chapple
Hon Tim Clifford
Hon Alanna Clohesy

Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Adele Farina

Hon Laurie Graham
Hon Colin Holt
Hon Kyle McGinn
Hon Martin Pritchard
Hon Samantha Rowe

Hon Matthew Swinbourn
Hon Dr Sally Talbot
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (*Teller*)

Amendment thus negatived.

Hon STEPHEN DAWSON: I move —

Page 13, line 19 to page 14, line 2 — To delete the lines and substitute —

(2) A medical practitioner is eligible to act as a coordinating practitioner or 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 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 or consulting practitioner for the patient.

I indicated previously when I spoke on Hon Nick Goiran's amendment why it was my intention to move this amendment. Again, I have listened to the contributions of various members throughout this debate and the government has taken those on board. I stand by the amendment standing in my name.

Hon RICK MAZZA: I rise to say that I support the amendment that has been put forward by the government. In doing so, I would like to say that it is good to see democracy at work and the house of review doing its job. A very important area of conflict has been identified by members of this place. This amendment takes care of any financial conflict or beneficiary conflict that may occur between practitioners and the patient. It is very pleasing that this has been identified. It is democracy at work and the house of review has certainly done its job in this case.

Hon ALISON XAMON: I rise to indicate that I will also be supporting this amendment. I think it is an important improvement to the legislation and reflects the policy intention of Hon Nick Goiran's previous amendment, which was defeated. It is essential to ensure that people who provide medical assistance for voluntary assisted dying can in no way personally benefit from their patient's death.

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Hon AARON STONEHOUSE: Contrary to comments in the press, democracy is not dead! It is alive and well through the process of amendments put forward and compromises reached and when, in this instance, legislation is enhanced and protections that were perhaps overlooked during the drafting have been included through amendment. We can now at least rest easy that conflicts of interest between patients and practitioners will be prohibited, which is something that I think everyone agrees to and everyone in the other place would agree to. I think this a vindication of members who have been interrogating this legislation in such detail. It is obviously frustrating for the public to look upon this process, as it may seem drawn out to the uninitiated, but this process is important. As I mentioned earlier, I am a little concerned that this does not address potential conflicts of interest in a relationship between consulting and coordinating practitioners. It is therefore not perfect in my eyes, but it is certainly an improvement over the status quo; therefore, I am happy to support this amendment.

Hon ROBIN CHAPPLE: I will certainly be supporting the amendment. These provisions were in both my bills and addressed this issue. The problem I have—it is something that we need to address and I repeat it again—is that if there are amendments out there, they should be on the supplementary notice paper so that it gives the government and members time to evaluate, come up with amendments or, as in this case, do what the minister has done and come up with a better alternative model. I support the minister's position.

Amendment put and passed.

Hon STEPHEN DAWSON: As members can see, there is a second amendment standing in my name. It is consequential.

Hon NICK GOIRAN: I note that the further amendment proposed by the minister is at a later point in the clause than the one proposed by Hon Colin Tincknell, so it seems to me to be in order that he move his amendment at 4/16 first.

The DEPUTY CHAIR: Thank you, Hon Nick Goiran.

Hon COLIN TINCKNELL: I move —

Page 14, after line 2 — To insert —

- (2A) A medical practitioner is eligible to act as a consulting practitioner for a patient if the medical practitioner —
- (a) holds specialist registration covering either or both of the following —
 - (i) palliative medicine;
 - (ii) at least 1 disease, illness or medical condition with which the patient has been diagnosed and which the coordinating practitioner for the patient has determined meets the requirements of section 15(1)(c);
 - and
 - (b) has practised the medical profession for at least 1 year as the holder of specialist registration as referred to in paragraph (a); and
 - (c) meets the requirements approved by the CEO for the purposes of this paragraph.

My amendment to clause 16 is all about further safeguards for patients, especially vulnerable patients. People, especially those who want to access VAD, need qualified decisions from specialists. I am very concerned about issues such as whether their condition is terminal or there are chances of further treatment or opportunities in palliative care. I understand there is an argument that we do not have specialists everywhere in regional areas and country regions. However, I am not the one putting VAD through; the government is trying to pass this bill, so we need to be better prepared for when this bill goes through. It looks like it will go through this chamber, and, as honourable members have mentioned before, some fantastic amendments have already been made, which is making this legislation better for the people of WA.

It is important that people get an opportunity to know from doctors with palliative care experience or a specialty in the disease that the person may be suffering from whether there is any other treatment or there has been a breakthrough in the disease that they previously thought they were going to be condemned by and lose their life to. I believe that if a doctor signs off on someone's voluntary assisted dying request but they do not have expertise in the disease that the person is suffering from, somewhere along the line, some mistakes will be made and there will be wrongful deaths. It is important that doctors with expertise are included in this decision. I mentioned before the argument that expertise would not be available to someone who lives in the regions; that is not good enough. As I said, we have been talking about palliative care and its shortcomings in the regions. The government is acting

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on that. We want more to happen and we need to monitor that as it happens throughout the passage of the bill and also the implementation stage. We also need to make sure that the government has a plan and that alternatives are available so that patients in the region can access specialists and get the full information on their disease.

Hon MARTIN PRITCHARD: At one point I would have been supportive of this amendment. I am sorry that I can no longer support it for a couple of reasons. Firstly, after a number of people spoke to me, I came to the realisation that before people access VAD, they will most likely have a number of specialist reports anyway, and trying to get specialists involved in the process by making them the consulting practitioner would severely limit the number of specialists available in not just the country, but also the metropolitan area. That came after a particularly enlightening briefing that Hon Colin de Grussa gave, in which we learnt that there are four motor neurone disease specialists in the state who look after 95 per cent of the patients in the state. We would need only a number of them to choose not to participate through either not receiving the training or conscientious objection or something along those lines. It would become problematic once we required a specialist to be involved in the process. As I mentioned before, by the time people get to the point at which they have a prognosis and request VAD, they probably would have had a number of specialist reports anyway, without involving them in the process. I commend the sentiment. It would be great if we could get to a point at which this was possible, but, unfortunately, I think it is detrimental to the bill and, for that reason, I cannot support it at this stage.

Hon STEPHEN DAWSON: I indicate that the government is not supportive of this amendment. The bill does not require that one practitioner is a specialist in the person's illness, but has a requirement for further independent assessment if there is doubt about the eligible medical illness, disease or condition. The position is consistent with views of the joint select committee and the Ministerial Expert Panel on Voluntary Assisted Dying. Both supported the ability for the coordinating and consulting practitioner to refer on for assessment of particular eligibility criteria rather than having a requirement that either of them must be a specialist in the disease, illness or condition that the patient has. Further, this difference in requirement from that in the Victorian act also reflects the practicalities of responding to the geographic remoteness of many places in WA and distance from medical care. The requirement to refer for further assessment serves to ensure specialist expertise when required. This ability to refer is consistent with current Australian medical practice and ensures that the patient has access to the highest standard of assessment in the voluntary assisted dying process.

Hon PETER COLLIER: This is an issue that I feel very strongly about and I thank Hon Colin Tincknell for putting forward this amendment. It pretty much mirrors the amendment that Hon Martin Pritchard initially put up and then withdrew. I have looked into it. I find it extraordinary that in this day and age we will have a situation in which one of the practitioners is not a specialist in the field. That, to me, is an oxymoron to this whole bill. Having said that, and I do not want Hon Colin Tincknell to take this personally, I cannot actually support this amendment. I will explain why. I was very, very insistent that in some shape or form we had sufficient safeguards so that the practitioners at least had access to information about someone who was going down the path of voluntary assisted dying. As a result, as a lot of us did, I worked very, very closely with the Australian Medical Association. I would like to put on the record my appreciation to the AMA, particularly Dr Andrew Miller, who was exceptional. I spoke daily—constantly—with Andrew over the last two or three months. I would also like to put on the record my appreciation to the Minister for Health, Hon Roger Cook, for the manner in which he has dealt with this issue. He is a breath of fresh air, I have to say, coming from the government. Dealing with Roger was very, very heartening to me. As a result of those negotiations that took place between the AMA and Hon Roger Cook in isolation and then collectively the three of us, we reached a point that assists in resolving the matter. That will come at clause 23, with an amendment from the government. Although it is not perfect—it is simply not perfect—the thing that got me across the line was that the AMA was very satisfied with it.

The clause in its current form, Hon Colin Tincknell, will inevitably have an adverse impact on those in the regions. To me, that is very, very important. It would be nice in a perfect, utopian world if that was not the case and we had sufficient specialists in the regions to cope with that situation, but unfortunately that is not going to happen. It would be nice, but it is not going to happen. Is that a reason, therefore, we do not support it? For me, I have not supported the second reading of this bill and at this stage I will not support the third reading, but I want to do all that I can to ensure that the bill is safer and that the safeguards that do exist are more stringent than those in the bill in its current form. With that said, I am comfortable, based on the negotiated agreement between the AMA and the health minister, and the discussions I have had with Hon Roger Cook and the AMA, that we have reached a landing point that I think goes a long way to improving those safeguards. I will have a bit more to say on clause 23; it will not be extensive. Suffice to say, I was really pleased with the manner in which those negotiations took place. I think that the health minister and the AMA were genuine in their desire to reach a landing point. I think we have done that with clause 23. For those reasons, and those reasons alone, even though in an ideal world I would support this amendment, I will not in this instance.

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Hon COLIN TINCKNELL: I really appreciate the Leader of the Opposition's words on this amendment. I was not privy to the meeting the Leader of the Opposition had with Hon Roger Cook. I have had meetings with the AMA, and it was very supportive of my amendment. I am aware that there is an issue with the country and that is one of the reasons the amendment is so important; it is something that the government should be addressing. It is a government-sponsored bill. It has chosen the time to put this bill through the house. The government needed to consider the geographical weaknesses in medical services in country regions before putting this bill to the house. This is something it has failed to do. The government has just wiped that out of the Victorian bill. For me, it lacks protections for vulnerable people. I really have concerns that a patient may access voluntary assisted dying not knowing that there has been a breakthrough in his disease just recently—I know it happens all the time—and that person could possibly have been given another option. That is one of the main reasons we need to have up-to-date specialists involved in deciding whether someone is going to take their life.

I will continue to move this amendment. I am very, very happy to compromise and work with the government and anyone else in the chamber, because we all have a conscience vote and we can make very good decisions if we work together.

Hon TJORN SIBMA: I want to speak to this motion moved by Hon Colin Tincknell with perhaps a degree of specificity as I actually understood the intention to be. I must say that I probably started at the position the honourable member has landed at, but I have changed my mind over the course of time and through consultation with a variety of medical specialists in a range of domains. Although I recognise the purity of the intent here, I have tried to maintain a line of pragmatism around the realities of medical consultation. In my view, it is highly unlikely that a patient would arrive at this particular position without extensive prior consultation with a range of specialists in the particular disease that they are suffering from. I really think that there is capacity—room—for specialist involvement. Indeed, I would be utterly surprised if somebody embarked upon this process for themselves without spending extensive periods of time in waiting rooms and in consultation with particular medical specialists.

I want to reflect on the honourable member's remarks about the disadvantage of people who live in rural and regional Western Australia. I completely concur with the sentiments that underlie the honourable member's motivation there, but for me it is another reason perhaps not to support this motion, because I think there is very limited capacity for people who live in regional Western Australia to obtain this kind of final specialist certification. From that perspective of equity and also from reflection on the reality of consultation and the progression of somebody's disease, although I recognise the intention behind the amendment, I cannot support it either.

Hon NICK GOIRAN: I am a little perplexed by what is happening here because I had understood that in an earlier part of the debate, members, the minister had given us an assurance—in fact, the word was a “guarantee”—that this government will ensure that if necessary, up to eight people will be flown out to regional Western Australia: the coordinating practitioner and if needs be an interpreter; the consulting practitioner and if needs be an interpreter; the administering practitioner and an interpreter; and, of course, because we are very concerned about regional Western Australia not being able to have the same level of access because of the inconsistency with commonwealth law, we will also make sure that there is a care navigator, an expert VAD steerer who will steer them down this whole path and if needs be with an interpreter. It is up to eight people. I asked the minister whether he would guarantee that the government would fly out those eight people if necessary. He said, “Yes. Cost is no issue to this government because we can't allow money to stand in the way when people are suffering at end of life.” If what the government has said is true—I take it at its word that it will fly up to eight people out there—perhaps someone can explain to me how difficult it is to put a specialist on the plane to be one of those eight people. Because that is all Hon Colin Tincknell is asking for here. He is saying that it has to be either a palliative care specialist or a specialist in the disease that the person says that they have. I would have thought that it would make no difference who the human being is on the plane. If we are going to fly out eight people, is it not a good thing if one of them is a specialist? If we do not do that, then the outcome is that we give second-class service to regional Western Australians. We say to them, “Sorry; we're not going to give you access to a specialist, because unfortunately you're too remote, so you are going to have to put up with somebody with lesser qualifications.”

The Northern Territory experience informs us that this is exactly what happens. I encourage members to have a look at the seven deaths in Darwin, where on one particular occasion the specialist was an orthopaedic surgeon, despite the fact the person had a condition called mycosis fungoides, which is a cancer in the blood that affects the skin. Dr Philip Nitschke ran around looking for a specialist, but he could not find one, so he kept doctor shopping and in the end it was an orthopaedic surgeon who had absolutely no qualifications in the underlying condition. That will not be a problem in Western Australia because this government will fly out the person—up to eight people if necessary. I do support the honourable member's amendment; it is consistent with the Victorian provision. Our legislation will be more dangerous than the Victorian legislation on this significant issue.

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Sitting suspended from 6.00 to 7.30 pm

Hon NICK GOIRAN: Prior to the adjournment, I had indicated that I would support the amendment moved by Hon Colin Tincknell. I note that the Australian Medical Association surveyed 1 500 doctors recently and revealed that 74 per cent of them believe that if neither of the doctors have a pre-existing therapeutic relationship with the patient, referral to a third independent specialist or the patient's usual doctor should be mandated as a safeguard. Is there any provision in the bill that requires the doctor to have a longstanding doctor–patient relationship with the person requesting access to voluntary assisted dying?

Hon STEPHEN DAWSON: No, there is not.

Hon COLIN HOLT: I rise to say that I cannot support the amendment moved by Hon Colin Tincknell. I want to back up the views expressed by Hon Tjorn Sibma when he talked about the fact that this cannot be viewed as an isolated journey. As I think I pointed out in my second reading contribution, when people get to this point, they are going to have had multiple contacts with specialists and doctors. I think the minister touched on this. There is a provision in the bill that says that if there is any doubt, or words to that effect, by the coordinating or consulting practitioner because they cannot diagnose or there is doubt about the illness, they can refer the matter to a specialist. I think there are those provisions in the bill. There will be lots of occasions on which there is probably no doubt about where the patient is at in their illness journey or about the fact that they are very, very ill. There would not be in much doubt, as seen by those consulting and coordinating doctors, that this is where things were at after they had viewed all the medical records, taken them into account and worked with the patient. I think there will be many, many occasions on which there will be no doubt. When there is some doubt, under this bill there is the ability, or the requirement, to seek that specialist care or input. Therefore, I cannot support the amendment moved by Hon Colin Tincknell.

Hon NICK GOIRAN: I was delighted by a portion of Hon Colin Holt's contribution just then. I might just draw to his attention the amendment standing in my name at 77/25, which deals exactly with that point the member raised.

Hon Colin Holt: Is it on the supplementary notice paper?

Hon NICK GOIRAN: Yes, it is.

The amendment seeks to insert the language, which Hon Colin Holt has just passionately spoken about, to indicate whether the specialist or the practitioner has any doubts about the situation. I look forward with enthusiasm, honourable member, to us walking together to the other side of the chamber when we get to clause 25!

Hon COLIN TINCKNELL: I will keep this brief. I thank everyone who has spoken on this important amendment. I know I possibly will not get it up, but I still think it is very important that it is something we debate. Whether we meet halfway or get an amendment that is close to it, this is what it is all about.

Division

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

Ayes (4)

Hon Nick Goiran	Hon Charles Smith	Hon Colin Tincknell	Hon Ken Baston (<i>Teller</i>)
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Noes (30)

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

Amendment thus negatived.

The DEPUTY CHAIR: Minister, you have an additional amendment following on from your previous amendment. Do you wish to move that amendment?

Hon STEPHEN DAWSON: Yes, I do have a consequential amendment on the special notice paper—not the supplementary notice paper, but the supplementary notice paper's supplementary! I have a second amendment that is consequential, and changes need to be made as a result of the insertion of the clause in relation to the medical

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practitioner not being a family member of the patient and the other point in relation to the will of the patient. I move —

Page 14, line 4 — To delete “subsection (2)(a), (b) and (c)” and substitute —
subsection 2(a)(i), (ii) and (iii)

The DEPUTY CHAIR: The Minister for Environment has moved, at page 14, line 4, to delete “subsection 2(a), (b) and (c)” and insert “subsection 2(a)(i), (ii) and (iii)”. The question before the chamber is that the words to be deleted be deleted.

Amendment (deletion of words) put and passed.

The DEPUTY CHAIR: The question now is that clause 16, as amended, be agreed to. I give the call to Hon Nick Goiran.

Hon NICK GOIRAN: Clause 16 provides that an overseas-trained specialist —

Point of Order

Hon MARTIN PRITCHARD: Do we now have to move that the words to be inserted be inserted?

The DEPUTY CHAIR (Hon Matthew Swinbourn): You are correct. That is right; we have missed that point. My usual helper did not help me out there.

Committee Resumed

The DEPUTY CHAIR: Following on from that, the question now is that the words to be inserted be inserted. In my defence, I have a lot of Sudafed in me.

Several members interjected.

The DEPUTY CHAIR: No. The question is on the minister’s amendment, that the words to be inserted—that is subsection 2(a)(i), (ii) and (iii)—be inserted.

Amendment (insertion of words) put and passed.

Hon NICK GOIRAN: Clause 16(2)(a)(iii), as it now is, provides that an overseas-trained specialist who holds limited registration or provisional registration may be eligible to act as a coordinating or consulting practitioner. Given the concerns raised in the ministerial expert panel’s final report around language and cultural barriers in Indigenous and culturally and linguistically diverse communities, does the minister have any concerns that overseas-trained practitioners may not have the appropriate skills and training to assess people from diverse cultural backgrounds across Western Australia?

Hon STEPHEN DAWSON: I am advised that these medical practitioners are registered to work in Australia. The training requirements in the bill mean that they will receive further cultural competency training.

Hon MICHAEL MISCHIN: Apropos the circumstances that Hon Nick Goiran outlined in which a consulting specialist could prove to be an orthopaedic surgeon with no skill or expertise in the disease from which the patient is suffering, is that in accord with the policy of the bill and is it desirable?

Hon STEPHEN DAWSON: I am advised that although it may be possible, it is highly unlikely that a patient would make a first request to an orthopaedic surgeon or, indeed, that an orthopaedic surgeon would take a first request from a patient. However, all medical practitioners will need to undergo mandatory training to participate in voluntary assisted dying. I make the point that an orthopaedic surgeon is still a very experienced medical practitioner, but the bill contains clauses that allow for referral to a specialist if a determination cannot be made by that orthopaedic surgeon, if that were the case, which again is highly unlikely.

Hon MICHAEL MISCHIN: We are not talking about just the initial consultation. Basically, the consulting assessment can be done by a practitioner who has been shopped around for and who will give the opinion that the first physician and the patient want. Is that correct?

Hon STEPHEN DAWSON: In the context of voluntary assisted dying, there are circumstances in which it is entirely appropriate for the person to approach another medical practitioner with a first request—for example, if they are having difficulty finding a practitioner willing to be involved in voluntary assisted dying or if their prognosis has changed. Therefore, the use of the term “doctor shopping” is a misnomer. A patient cannot seek another consulting practitioner, as it is the coordinating practitioner who makes the referral to the consulting practitioner. The use of the term “doctor shopping” in relation to voluntary assisted dying also creates negative connotations of the integrity and skill of medical practitioners involved in the voluntary assisted dying process. Those practitioners are experienced doctors who must have undergone and passed mandatory education. That

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process requires also two independent assessments of eligibility, which is a further safeguard against the most perceived risk of doctor shopping.

Hon MICHAEL MISCHIN: Hon Nick Goiran outlined the circumstances in which Dr Nitschke was having trouble finding someone prepared to give a second opinion and endorsement of the course that the patient and Dr Nitschke wanted to take. They looked around, found someone who had no experience in that particular disease, and that was the level of consultation and the consulting assessment. Can that happen under this bill? Is it possible that a doctor such as Dr Nitschke, with a patient who wants to terminate their life through a state-sanctioned mechanism like this, can find a practitioner who will endorse that course of action, even though they have no experience in that particular disease?

Hon STEPHEN DAWSON: I am not going to comment about Dr Nitschke, who operated in a territory under different legislation. If a medical practitioner, a coordinating practitioner, is unable to determine, the coordinating practitioner must refer the patient to a registered health practitioner who has the appropriate skills and training to make a determination on the matter.

Hon MICHAEL MISCHIN: The minister is assuring us that that situation cannot arise under this regime, having regard to the 102 safeguards that have been implemented to ensure the integrity of the model. Is the minister able to assure us that that cannot happen in Western Australia?

Hon STEPHEN DAWSON: I will answer it in this way: the bill provides a model for accessing voluntary assisted dying. We cannot make assurances about illegal or unethical acts.

Hon NICK GOIRAN: I was happy to move on to the next clause, but I was intrigued by the minister's response to Hon Michael Mischin suggesting that doctor shopping is somehow a misnomer, notwithstanding the fact that the honourable member raises the example of the lived experience in the Northern Territory. I will give one further example of doctor shopping in Oregon. It is important to remember that the model before us is supposedly based on legislation in either Victoria or Oregon. The first known assisted suicide death in Oregon represents a clear example of doctor shopping. I draw members' attention to the minority report from the yearlong inquiry of the Joint Select Committee on End of Life Choices. Paragraph 3.165—no doubt a paragraph that has not been read by anyone in government—states —

This was a patient whose name is unknown, who was in her mid-eighties and who had been battling cancer for twenty-two years. Initially, two doctors, including her own physician who believed her request was due to depression, refused to prescribe her lethal drugs. Compassion & Choices in Oregon, then operating under the name Compassion in Dying, became involved in her case and referred the woman to a doctor willing to write the prescription.

Unfortunately, that is exactly what happens in those jurisdictions. There is no point asking the government about that because we already know from our interrogation under clause 1 that neither the government nor the joint select committee nor the ministerial expert panel has looked into any of the lived experiences in the international jurisdictions. A few people have spent a few cursory moments in time looking at the legislation in some of those jurisdictions, but never into the lived experiences. I am happy for us to move off clause 16, but any suggestion that doctor shopping is a misnomer can only be articulated by individuals who have not studied the experience in the other jurisdictions.

Clause, as amended, put and passed.

The DEPUTY CHAIR: There is an amendment on the supplementary notice paper in the name of Hon Charles Smith. Does the honourable member propose to move his amendment?

Hon CHARLES SMITH: Noting the similarity of this amendment and the amendment moved previously, and noting the chamber's complete lack of interest in that amendment, I will not move my amendment to insert new clause 16A.

Clause 17: Person may make first request to medical practitioner —

Hon NICK GOIRAN: To what extent is a clause 17 first request made via clause 156(2)(a) restricted by sections 474.29A and 474.29B of the commonwealth Criminal Code Act 1995?

Hon STEPHEN DAWSON: If the patient makes the first request, it will not be an issue, because the patient is initiating the discussion with the practitioner.

Hon NICK GOIRAN: I think the minister moved an amendment earlier that was a variation on what has been referred to as the Buti amendment, which will allow the initiation by practitioners of this discussion. For discussions that are initiated by a practitioner, how will this be impacted by clause 17, clause 156 and the commonwealth Criminal Code Act?

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Hon STEPHEN DAWSON: Discussions initiated by a practitioner would need to be made face to face.

I move —

Page 14, after line 11 — To insert —

(aa) made during a medical consultation; and

This proposed amendment assures that a first request can be made by a patient to a medical practitioner only during a medical consultation. This paragraph has been included following consultation with the Australian Medical Association and the government considers it to be a good amendment. The proposed amendment will remove any obligation from a medical practitioner who is not in a medical consultation from having to report a request to access voluntary assisted dying to the board or provide information to a patient. Only when the first request is made—that is, a valid request under clause 17 of the bill—will the obligation to report to the board and give information to the patient be triggered. The effect of this proposed amendment is that medical practitioners who are not in the setting of a medical consultation, such as full-time researchers, medical administrators, retired doctors or doctors in a social setting, will not be required to lodge a first request form with the board nor to provide the patient with information about the VAD process. Thus, only eligible practitioners—those who meet the requirements under clause 16—or a practitioner who may be ineligible but is within a medical consultation scenario and to whom a first request has been made, will have to report to the board and provide information to the person making the first request. Clause 16 of the bill currently sets out the eligibility requirements for a medical practitioner to act as a coordinating or consulting practitioner. Clauses 16(2)(a) to (c) specifically require that in addition to meeting certain registration requirements, the medical practitioner must also meet requirements approved by the CEO. The very intent of this is to further narrow the types of medical practitioners who can act as the coordinating or consulting practitioner; that is, they cannot be working solely in management or research roles. The proposed amendment to clause 17(2) supports this.

Hon NICK GOIRAN: Given that “medical consultation” is not defined anywhere in the bill, does any other Western Australian statute use that term?

Hon STEPHEN DAWSON: I do not have an answer to that. My advisers cannot tell me whether it is used elsewhere. But it is a commonly used and understood term.

Hon NICK GOIRAN: I can tell the minister that it is not used in any Western Australian statute. In the absence of any statutory guidance, how will this term be interpreted?

Hon STEPHEN DAWSON: It will be the ordinary plain English meaning.

Hon NICK GOIRAN: Would a clause 17 first request made by clause 156(2)(a) constitute a medical consultation?

Hon STEPHEN DAWSON: I am advised that if the patient is in a medical consultation via telehealth, they may make a first request during it.

Hon NICK GOIRAN: Given that there will be serious consequences for medical practitioners in the event that they contravene any aspect of this legislation, I think it is appropriate that the medical practitioners in Western Australia understand how “medical consultation” will be interpreted. There is no definition in this bill, it is not a phrase used in any other statute and I am concerned that a medical practitioner may be found in contravention of the legislation simply by virtue of whether the circumstances in which they have a conversation with another person is defined as a “medical consultation”. What criteria can a Western Australian medical practitioner rely on to determine whether a dialogue between them and another person is or is not a medical consultation?

Hon STEPHEN DAWSON: I make the point that medical practitioners understand what a medical consultation is. It is a phrase used by medical practitioners and supported by the Australian Medical Association.

Hon NICK GOIRAN: Given that it is a phrase that medicos and the AMA use, is that commonly used phrase defined somewhere in some kind of code of conduct or in some other manuals? Is this something that medicos are taught at the University of Western Australia or the University of Notre Dame as they go about their training? It is so commonly used that all these medicos understand it, unlike members of the Legislative Council, so it must be recorded somewhere. Can the minister indicate where that is?

Hon STEPHEN DAWSON: I say it again: medical practitioners understand what it is. It is certainly used by Medicare with rebates and billing.

Hon AARON STONEHOUSE: I am glad to see this amendment because it addresses something I raised when we discussed division 3 and the terms used. I raised some questions around the definition of “patient” and the broad definition used in clause 5, because on a first reading it seemed to me that a person could make a clear and unambiguous request for voluntary assisted dying in a very unofficial way. That would trigger obligations for

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a medical practitioner to record the conversation they had with that patient on their medical record and submit forms to the board. That may happen despite the fact that the medical practitioner has no idea who this person or patient is. It may be a casual passing, whereby somebody approaches someone who they know is a doctor, but the doctor has no idea who this person is. They could make an unambiguous request for voluntary assisted dying without the doctor having any idea who that person is, with no access to their medical records and, perhaps, depending on the setting, not being able to follow up with that person to fulfil their obligations under division 2. Can the minister confirm that this amendment addresses the concerns I have raised, that if it is during a medical consultation it will ensure that in the scenario I described—somebody passing a doctor in the hall and making a request for voluntary assisted dying—the medical practitioner would not have those obligations triggered and the obligations under clauses 19 and 20 and so on would be triggered only if that request was made during a medical consultation?

Hon STEPHEN DAWSON: That is correct.

Hon AARON STONEHOUSE: I am glad to hear it. That addresses my concern, in which case I am happy to support the amendment put forward by the minister.

Amendment put and passed.

Hon NICK GOIRAN: The Victorian mandatory training for health practitioners involved in providing voluntary assisted dying notes red flags in the training module on the assessment of decision-making capacity. One of those red flags is that the patient can only communicate through gestures and appears to respond to questions inconsistently. Can the minister explain to the chamber how the bill can provide for non-verbal communication by the patient, while at the same time requiring the coordinating and consulting practitioners to ascertain that the patient has decision-making capacity in light of this red flag highlighted in the Victorian training module?

Hon STEPHEN DAWSON: If the medical practitioner cannot reliably determine decision-making capacity, the patient will not meet the criteria.

Hon NICK GOIRAN: Although the WA bill provides that a person may make a first request to a medical practitioner, as the minister knows, it does not contain the equivalent of the Victorian provision at section 8, which states that a VAD discussion cannot be initiated by the registered health practitioner. Our bill has been amended to mandate that any doctor-initiated VAD discussion must be accompanied with advice on treatment options, but could voluntary assisted dying be recommended to a patient by a medical practitioner, either pre or post a first request?

Hon STEPHEN DAWSON: I am advised that they can be informed about it as an option.

Hon NICK GOIRAN: I know they can be informed of it as an option; that is not my question. I want to know whether it can be recommended by a medical practitioner. That is a different thing altogether.

Hon STEPHEN DAWSON: The bill contains carefully considered neutral language in relation to a patient being informed or provided with information; it is not about making recommendations.

Hon NICK GOIRAN: Would the minister be willing to take it on notice—speak to the Minister for Health—and come back to us tomorrow about inserting a prohibition on a medical practitioner recommending voluntary assisted dying for a patient? I accept what the minister is saying about neutral language. I take it that the intent of government, and I would like to think of all members in this chamber, is that if we are going to have this scheme, it is quite one thing for a medical practitioner to initiate the conversation with a patient, but it is another thing for them to recommend it. I find really distasteful the idea that a medical practitioner could see a patient and say, “I recommend that you access voluntary assisted dying.” That is a very significant step. It is different from a patient saying to a doctor, “Doctor, I’m concerned. I’ve had enough and I want to access this voluntary assisted dying. Can you please inform me about my options?” and a conversation takes place or the doctor says to the patient, “These are all things that are available to you in Western Australia, including voluntary assisted dying, as a suite of options.” I think a doctor saying to a Western Australian patient, “I recommend you access voluntary assisted dying”, should be prohibited. I do not think there should be a place for that in our state. I do not expect the minister to be able to determine a position on that off the cuff, right now, but I would like an indication whether he would be willing to take that up with the health minister. If there was agreement in government that that is an appropriate prohibition, it might find a place in a later stage of the bill to put that in.

Hon STEPHEN DAWSON: I am happy to take the issue away and ask the question.

Clause, as amended, put and passed.

Clause 18: No obligation to continue after making first request —

Hon NICK GOIRAN: Why is it necessary to include clause 18 in the bill at all?

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Hon STEPHEN DAWSON: This clause reflects the voluntary and enduring nature of requesting access to voluntary assisted dying and that in order for the process to continue, the patient's choice to participate is paramount. The patient is not obliged at any stage of the process, even after the completion of the request and assessment process, to take any further action in relation to accessing voluntary assisted dying.

Hon NICK GOIRAN: What mechanism in the bill ensures that the Voluntary Assisted Dying Board is notified if patients avail themselves of their clause 18 right?

Hon STEPHEN DAWSON: There is no formal process or time requirement to withdraw from the process. The patient may simply state that they do not wish to proceed. The request and assessment process ends if the patient decides not to continue the process. If the patient subsequently wishes to access voluntary assisted dying, they may begin a new request and assessment process by making a new first request.

Hon NICK GOIRAN: Do I take it from that that at the moment, if the bill is unamended, the board will never know whether a patient has accessed their right under clause 18 and requested the process to end?

Hon STEPHEN DAWSON: There is no requirement to notify the board.

Hon NICK GOIRAN: Would the proposed amendment that inserts new clause 52A be a mechanism that would ensure that the board is notified in the event that a patient avails themselves of their rights under clause 18?

Hon STEPHEN DAWSON: It appears so.

Hon NICK GOIRAN: I congratulate Hon Charles Smith on his amendment to insert new clause 52A, because the minister has just indicated that that would be a mechanism that would ensure that the Voluntary Assisted Dying Board would be notified if a patient avails themselves of their rights under clause 18. Rightly so, I might add, because it troubles me that at the moment the bill is silent on this point, and, quite rightly, this clause states that a patient does not have to continue the process. Of course, they should not have to continue the process, but then it states at clause 18(3) that if they want to start the process, they have to begin again by making a new first request. The board would be none the wiser about any of that, particularly if the medical practitioner was unfamiliar or unskilled in the process that is set out in this particular bill. I look forward to consideration of new clause 52A when we get there.

Hon COLIN TINCKNELL: I refer to clause 18(3), lines 21 to 23. How many first requests, or new requests, can a person make? Is there a limit?

Hon STEPHEN DAWSON: There is no limit.

Clause put and passed.

Clause 19: Medical practitioner to accept or refuse first request —

Hon NICK GOIRAN: What information will be provided to the patient under clauses 19(4)(b) and 19(5)(b)? Will this information include a list of the practitioners who have undertaken the mandatory training and are willing to act as coordinating and consulting practitioners?

Hon STEPHEN DAWSON: No, it will not.

Hon NICK GOIRAN: I think the minister only heard the second part of my question. The first part of my question was: what information will be provided to the patient under those clauses?

Hon STEPHEN DAWSON: I did not hear that bit, sorry; I did only hear the second part. Standardised information regarding the voluntary assisted dying process—for example, eligibility criteria, access points, supports, and that a patient's consent to assisted dying may be withdrawn at any time—will be developed during the implementation stage and made available to all health practitioners for provision to persons who make a request or require information regarding voluntary assisted dying.

Hon NICK GOIRAN: Will the information that the CEO will require medical practitioners to provide on pain of contravention of the act be tabled in Parliament?

Hon STEPHEN DAWSON: I do not think that the honourable member is asking for it to be made available and tabled now in Parliament, because it does not exist at this stage.

Hon Nick Goiran: No.

Hon STEPHEN DAWSON: It will be put together as part of the implementation phase. As to whether it could be tabled in the future, I cannot see why not.

Hon AARON STONEHOUSE: It is pretty fair to say, based on the answers the minister has just given, that the information to be provided under clauses 19(4)(b) and 19(5)(b) would be fairly comprehensive. It is not going to

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be something as simple as a URL or the telephone number of some hotline; it will be fairly comprehensive information. Can we expect that to take the form of a brochure or an information pack? What will it actually look like? How large will it be?

Hon STEPHEN DAWSON: That will be determined during the implementation phase, after consultation with the appropriate people.

Hon AARON STONEHOUSE: Under the newly amended clause 17, will there be an obligation for the information under clauses 19(4)(b) and 19(5)(b) to be provided only if a request for voluntary assisted dying is made during a medical consultation, or will there be an obligation for that information to be provided during a more casual conversation? For instance, if a person walked into a reception and asked the receptionist for that information, would there be an obligation for that information to be provided?

Hon STEPHEN DAWSON: The obligation exists only under the first point that the member made.

Hon AARON STONEHOUSE: The medical consultation?

Hon STEPHEN DAWSON: That is it.

Hon ADELE FARINA: Will the information include the potential risks associated with the administration of a voluntary assisted dying substance and the fact that the death may not be pain free and peaceful?

Hon STEPHEN DAWSON: That information will vary depending on the patient. The short answer is no; there will be a general information pack available, but what the honourable member is suggesting would be specific to individual patients. That information would not be included in the general information pack, but it may well be provided. That is provided for under clause 26.

Hon ADELE FARINA: Could the minister please explain to me how the information that I have suggested should be provided is specific to different patients? I am asking about information on the general risks associated with the administration of the voluntary assisted dying substance.

Hon STEPHEN DAWSON: There may be general commentary about the risks, but that will be determined during the implementation phase. There will not be commentary on the specific risks associated with a patient taking a particular substance to access voluntary assisted dying.

Hon AARON STONEHOUSE: I will just ask the minister one more hypothetical question on this. Can we expect that information about palliative care will be provided in this information pack provided by the CEO to medical practitioners? One other point: will information for victims of elder abuse also be provided as part of that information pack? It sounds like it will be pretty comprehensive in covering the voluntary assisted dying aspect. Will it be comprehensive in providing people with more information about their alternative choices to voluntary assisted dying and, in fact, giving them information that might be useful if they are a victim of elder abuse?

Hon STEPHEN DAWSON: The content will be developed during the implementation phase. I will bring the member's suggestion to the attention of the department; in fact, people from the department are here. But in relation to the specific palliative care information that is given to patients, clauses 26 and 37 deal with that.

Hon AARON STONEHOUSE: I would really appreciate it if consideration were to be given to providing information about palliative care in that information pack. I understand that there is an obligation to provide information about palliative care later in the process, at clause 26 and so on, and if the medical practitioner is the person who raises the question of voluntary assisted dying with the patient. However, proposed section 19(5)(b) is triggered only if a medical practitioner refuses to go through with the voluntary assisted dying request and refuses to become the coordinating practitioner. In that instance, when a medical practitioner refuses to carry out a request and they provide this information and send someone on their way, I think it would be very helpful for the patient who has taken this information home to digest to have everything relevant to their end-of-life care at hand. I think it would be very helpful for those people to be provided with information about palliative care in addition to voluntary assisted dying in that information pack. I would appreciate it if that is given consideration when the information is developed.

I have one more question for the minister. Is the obligation on medical practitioners in clause 19(5)(b) replicated in the Victorian Voluntary Assisted Dying Act 2017?

Hon STEPHEN DAWSON: I am advised that it is not.

Hon AARON STONEHOUSE: Is it replicated in the Oregon legislation, which I am told the Victorian regime and our regime is modelled on?

Hon STEPHEN DAWSON: Honourable member, I do not know. I am not sure whether my advisers have that information here. I am not sure what the relevance is. Perhaps the member wants to make his point and I can give an answer. But I do not know at this stage. I might be able to get it, but we do not know at this stage.

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Hon AARON STONEHOUSE: That is okay, minister; thank you for that. The reason I ask is I am trying to see whether such obligations are replicated in similar jurisdictions to our own. Comparing us with the Netherlands or Belgium, I do not think is really helpful. But looking at Victoria—another Australian jurisdiction—or Oregon, which the Victorian legislation and our own legislation is modelled on, would be helpful in informing us whether such an obligation is included in their legislation and is necessary, how their voluntary assisted dying schemes operate in the absence of such an obligation and whether there are problems with patients being informed of the option for voluntary assisted dying in the absence of such an obligation. I will sit down for now because I think other members have questions along a similar line.

Hon RICK MAZZA: I will just step through this, minister. Someone has a medical consultation and they ask their doctor about voluntary assisted dying and the doctor is a conscientious objector. Does the doctor simply need to give the patient a pamphlet, or whatever the CEO-approved information is, and send the patient on their way? Is there a requirement for the medical practitioner to make a report to a board or anything? If they do not give the information, do any penalties apply?

Hon NICK GOIRAN: While the minister is finding the answer, the honourable member might like to know that earlier today the minister tabled a schedule as per a discussion we had last week, and it sets out all the different clauses, including the penalty if the practitioner has contravened anything. The schedule that was tabled earlier today refers to clause 19(5)(b), which provides for giving a patient information approved by the CEO. When the medical practitioner has a conscientious objection and does not provide the information, it will not constitute a criminal offence under the bill, but it will enliven clause 10 of the bill whereupon any associated penalties are determined by the Health Practitioner Regulation National Law (WA). Therefore, in other words, it will be some kind of misconduct. It will not be a criminal offence, but it is still a very significant penalty imposed on a medical practitioner who says, “I don’t want to be involved in this”, and suddenly we say to them, “You’ve now committed misconduct.”

Hon COLIN TINCKNELL: Further to that question, what if the medical practitioner is not a conscientious objector but he believes that the patient is making a mistake by seeking to access VAD?

Hon STEPHEN DAWSON: If the medical practitioner refuses the first request, they still have the responsibility to provide the information.

Hon NICK GOIRAN: Therein lies the problem in which we have a medical practitioner who says, “Look, I’m very concerned about this particular patient. I don’t think they should be accessing voluntary assisted dying”, for example, “because I think that this particular individual is depressed, so I’m not going to facilitate this process. I’m going to choose, under clause 19(2), to say that I’m unwilling to perform the duties of a coordinating practitioner. I’ve done the training, but I’m not going to perform it with regard to this person because I believe this person is depressed”, yet we as legislators are now going to say to that doctor that they have to provide this information approved by the CEO. That troubles me.

It brings me to a question I have. Why is it that under clause 19(5), we oblige a practitioner who has a conscientious objection to immediately inform the patient, whereas everybody else has two business days? Under clause 19(2)(a), a person might be unwilling to perform the duties; under subclause (2)(b), a person might be unable to perform the duties; or under subclause (2)(c), a person may refuse the request because they are not eligible to act. In any of those scenarios, we give the practitioner two business days to inform the patient. But if they are a conscientious objector, we really punish them and make sure that they have to inform the patient “immediately”. Why was it decided that the conscientious objector has to inform the patient immediately, but everybody else, including the person who is unable or unwilling or does not even qualify to participate, has two business days?

Hon STEPHEN DAWSON: First of all, it is not about punishment, it is about the best interests of the patient. Subclauses (4) and (5) create a positive duty on the medical practitioner to inform the patient of their acceptance or refusal of the first request. This reflects the position that a medical practitioner is professionally obligated to not unduly delay a patient’s access to voluntary assisted dying. They should make a decision and inform the patient as quickly as possible. If the medical practitioner is a conscientious objector, they must inform the patient of the refusal immediately after receiving the first request. For other reasons, as Hon Nick Goiran pointed out, the medical practitioner must advise the patient within two business days of the request. This provision takes into consideration that a person who conscientiously objects to voluntary assisted dying will refuse a patient’s request as a matter of course. Thus, this medical practitioner does not require a length of time to come to that decision and there is no reason to delay notification to the patient. However, other medical practitioners may require time to consider whether they are available or able to provide this service to the patient—for example, the medical practitioner cannot schedule the patient in, or they do not meet one or more of the minimum requirements to be a coordinating practitioner.

Hon NICK GOIRAN: What absolute rubbish, minister, because a practitioner who has not fulfilled the training requirements knows instantly that they are not able to participate. I draw the minister’s attention to subclause (3). It states —

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The medical practitioner must refuse the first request if the practitioner is not eligible to act as a coordinating practitioner.

The medical practitioner knows that immediately; they have either done the training or they have not. The suggestion that somehow the conscientious objector is the only type of medical practitioner who understands instantly and then has to tell the patient makes no sense in light of subclause (3). It is not at all clear to me why we are—in my language—punishing the conscientious objector. Nevertheless, could it be the case that a conscientious objector has not done the training and is therefore not eligible to act as a coordinating practitioner? In that instance, they qualify under subclauses (2)(a) and (3). Do they get two business days to inform the patient or do they have to inform them immediately?

Hon STEPHEN DAWSON: If a medical practitioner meets the minimum requirements, other than having done the mandatory training on voluntary assisted dying, they are able to do so after the first request and prior to undertaking the first assessment.

Hon AARON STONEHOUSE: I would like to pick up on something that was raised by Hon Nick Goiran—that is, the obligation for a medical practitioner to provide the information laid out by the CEO in instances when they are not necessarily conscientious objectors, but they are unwilling to perform an assessment and become a coordinating practitioner because they know, perhaps for a fact, that a patient is ineligible. Maybe they know that a patient has severe depression or some cognitive impairment, or perhaps they know that the patient is under the age of 18. It seems to me that we are creating an obligation here by which a 16-year-old or even someone younger could walk into a medical practice and during a medical consultation make a request for voluntary assisted dying, and there would be an obligation on the medical practitioner to provide the information pack laid out by the CEO. Am I wrong in that reading of the obligations in clauses 19(4)(b) and 19(5)(b), or have I got that right?

Hon STEPHEN DAWSON: They are required to provide the information. It does not mean that the patient can access it straightaway. It is our belief that the doctor should communicate his or her concerns to the patient. The patient would still have to undergo the assessment process with relevant practitioners. I think the member also alluded to people under 18. Can I just make the point that if someone is under 18, they are not eligible.

Hon Aaron Stonehouse: But there would be an obligation to provide information.

Hon STEPHEN DAWSON: Let me clarify that. Yes, they would be under an obligation to provide it.

Hon AARON STONEHOUSE: Madam Deputy Chair (Hon Adele Farina), I am sure you can understand why I am deeply concerned about this. There could be a situation of someone under the age of 18 making inappropriate requests for voluntary assisted dying and a medical practitioner would have an obligation to provide information about it to that person. There may also be an instance of a medical practitioner knowing that their patient has suicidal ideation. That patient could make a request for voluntary assisted dying and the medical practitioner would have an obligation to provide information about voluntary assisted dying. I think that is grossly inappropriate, and it could lead to some serious harm. Without adequate protection for medical practitioners who refuse to provide that information, vulnerable people at serious risk of harm could be provided information about voluntary assisted dying. I know we have gone to pains not to use the word “suicide” in this instance, but providing that kind of information to somebody who suffers from suicidal ideation or has a severe mental illness is going to put those people at great risk of harm, and I am very, very concerned about that. It is something I do not think we have really appreciated until we have had the chance to interrogate this clause, but I think all members should be concerned about that obligation on medical practitioners in this instance. Without a way to opt out, without any discretion afforded to medical practitioners, we will be putting them in a horrible situation in which even if they know it will cause harm, they will still be obliged to provide information. They will be compelled to do so, and if they do not, there will be professional misconduct. They may be potentially stripped of their ability to practise for refusing to participate and provide the information they are compelled to.

Hon ALISON XAMON: I respectfully disagree with the concerns being raised by Hon Aaron Stonehouse on the basis that if a medical practitioner is faced with this situation that has been described by the honourable member, in theory they may be obliged to provide the basic information, but that basic information would make it very clear that the person who may be experiencing suicidal ideation is simply not eligible to avail themselves of this. What it does do is open an opportunity with a clinician to talk to that person about their mental health issues and the fact that they are experiencing suicidal ideation. Fifty per cent of mental health presentations first occur with general practitioners. It is a very, very common occurrence, and one that general practitioners have to deal with at least weekly, sometimes on a daily basis. Part of their training is to learn how to respond to people who are experiencing deep mental health stress and then to address the issues accordingly. I do not think that the supply of the information is going to pose the sort of risk that is being contemplated by the honourable member. I think it clarifies that voluntary assisted dying is not the appropriate course of action, or even available in this instance. It opens up the opportunity for a therapeutic response to deal with serious mental health issues.

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Hon NICK GOIRAN: I am reminded of a case that was shown in the documentary *Fatal Flaws*. A young lady in the Netherlands continued time and again to try to have access to voluntary euthanasia as it is in the Netherlands. There is a very sad scene in which the filmmaker, Kevin Dunn, is in this dialogue with this lady, and he continues to follow up with her afterwards, but she is insistent that she wants to access this. She acknowledged, and I think it was obvious from the documentary, that she suffered from some form of mental illness, and that was the reason that she wanted to access euthanasia. It is true that under the eligibility requirements we agreed to earlier under clause 15(2), a person is not eligible to access VAD only because they have a disability or have been diagnosed with mental illness. That is true, but Hon Aaron Stonehouse's point is that in the meantime the practitioner, knowing this, still has to provide information. I would have thought that the only circumstances in which a doctor should have to provide this information for a patient would first of all be if the doctor knows that the person is over 18 years of age. If the person is not 18 years of age, the doctor should not have to provide this information. If the doctor knows that the person has not been ordinarily resident in Western Australia for the last 12 months, they should not have to provide information. If they know the person does not have a terminal illness because they are in a longstanding therapeutic relationship with the person, they should not have to provide the information.

Above all else, even if members do not agree with me on all of those points and say that practitioners should still provide the information, surely to goodness if the practitioner has a longstanding relationship with the person and they can see that this person has been coerced by a family member, that should be enough for the practitioner to say, "I am hitting the pause button here. I cannot provide you with this information. Why? Because I am going to exercise the right that is available to me under clause 19(2), which says that I am otherwise unwilling to perform the duties." That should be enough. I do not see why we then create this mandatory requirement upon this clinician, who in all good faith says that they are not going to provide this and that they are not going to participate, but they still have to steer the person in the other direction. I, like Hon Aaron Stonehouse, am concerned about this provision. I note that unlike clause 19(5), by which we in Western Australia are going to force our practitioners to provide information, in Victoria not only are practitioners not forced to do that, but they have a statutory right to say that they will refuse to provide information about voluntary assisted dying. Victoria basically does the exact opposite of us. Victoria says, "Medicos, if you do not want to provide information about voluntary assisted dying, you have a statutory right not to provide it." In Western Australia we say, "Forget that, you do not have any such right. In fact, you have an obligation under this law to provide information." I am grateful that I am not a medical practitioner. I think we are doing the wrong thing here.

Hon STEPHEN DAWSON: While I have it at hand, referring to the Oregon legislation and the member's earlier question, Oregon legislation requires the patient to make an informed decision; however, it does not include provisions such as found at clause 19(5)(b). That is in relation to that issue.

It is important to note that mature minors can currently make their own medical decisions. That happens today. As we have said, the bill requires that for someone to access voluntary assisted dying, they must be a minimum of 18 years of age. If a doctor were not to give that information because they thought that a person was under age or mentally unwell, what could happen? Under clause 10 of the bill, the patient could potentially report the doctor, which states —

- (1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.

The reality is that if it were reported and investigated, it is likely that no breach would be found because the people investigating it would recognise that the patient was under age and that the doctor had made a legitimate decision by not providing it. Further, in relation to the residency issue, a person who ordinarily may be resident or have a condition just outside the criteria should be able to avail themselves of information before they make a valid first request.

Hon AARON STONEHOUSE: I thank the minister for providing that information on Oregon. I appreciate the reassurances provided by Hon Alison Xamon. I understand, I suppose, the view that the information provided to medical practitioners by the CEO would ideally address concerns about people with mental illness who are seeking appropriate help and not going down the avenue of voluntary assisted dying. I remain concerned, however, that someone in a very vulnerable state who is provided with information about voluntary assisted dying may pose a harm in some instances, especially in the case of someone under the age of 18 who is very vulnerable and very susceptible to suggestion and would, perhaps, not have the same powers of reason that a fully formed adult might have. They might read that information and it might plant in their mind the seed of an idea about causing their own death. I remain concerned about that. We do not know at this time what will be in the information pack provided by the CEO. I certainly hope that it is comprehensive information that points people to mental health services, and provides information to victims of elder abuse and information about palliative care. But at the moment I am concerned that it may not, and I am concerned about what seems to be a lack of discretion for medical practitioners

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who may know what best information to provide to their patients at the time, but would be obliged to provide the information that the CEO tells them to provide.

Originally, my interest in this clause was around conscientious objectors, but on closer reading and seeing that subclause (2)(a) refers to “otherwise unwilling to perform the duties of a coordinating practitioner”, I took more of an interest in the issue around medical practitioners who may know that their patient is ineligible or may have some perhaps not conscientious objection, but ethical objection to providing information that sits outside the bounds of their religious, cultural or moral beliefs about voluntary assisted dying. It is that lack of discretion that I think will do the most harm. Depriving medical practitioners of the ability to assess their patient’s situation, perhaps even their patient’s mental state at that time—although they may not be the best placed clinically to do so, they do have that longstanding relationship and, as was pointed out by Hon Alison Xamon, they are on the front line to assess the mental health of the public in a lot of ways because they do provide referrals to mental health services—I fear may cause harm, if they are not able to exercise their judgement appropriately in those instances. In any case, Mr Chairman, I have an amendment that I hope addresses these problems. I move —

Page 15, lines 19 to 26 — To delete the lines and substitute —

- (5) If the medical practitioner refuses the first request under subsection (2)(a), the practitioner must, immediately after the first request is made, inform the patient that the practitioner refuses the request.

As I pointed out a moment ago, the Victoria legislation contains no such obligation, and, as was pointed out by the minister, neither does Oregon. Oregon is the basis for the Victorian legislation and our legislation. We have obviously borrowed a lot from the Victorian legislation in the drafting of this bill. It is worth recognising that section 7 of the Voluntary Assisted Dying Act 2017 in the Victorian regime, under the heading “Conscientious objection of registered health practitioners”, states —

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

- (a) to provide information about voluntary assisted dying;
- (b) to participate in the request and assessment process;
- (c) to apply for a voluntary assisted dying permit;
- (d) to supply, prescribe or administer a voluntary assisted dying substance;
- (e) to be present at the time of administration of a voluntary assisted dying substance;
- (f) to dispense a prescription for a voluntary assisted dying substance.

Victoria’s legislation not only is lacking in obligation for medical practitioners to provide information, but also expressly provides them the right to not do so. Why it is missing in the case of the Western Australian bill is somewhat of a mystery to me. It had always been my impression that Victorians were a little more progressive than we were here. However, we have pursued a slightly different regime that will place upon medical practitioners the obligation to provide information; that is, members, despite the principles of the bill. I refer members to division 2, clause 4, “Principles”, and subclause (1)(j), which reads —

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

In fact, later in division 4, clause 9 states —

- (1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —
- (a) participate in the request and assessment process;
- (b) prescribe, supply or administer a voluntary assisted dying substance;
- (c) be present at the time of the administration of a voluntary assisted dying substance.
- (2) Subsection (1) is not intended to limit the circumstances in which a registered health practitioner may refuse to do any of the things referred to in that subsection.

Clause 9 of the Western Australian bill is essentially section 7 of the Victorian bill; however, clause 9 of the Western Australian legislation is absent a protection and a right for medical practitioners to refuse to provide information about voluntary assisted dying. I pointed out previously that I think it is undesirable that in a bill in which we have gone to great pains to ensure that there is no coercion, and that the bodily autonomy and the sovereignty of

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patients is respected and that patients will be free to make their own choices about their own health care, and in which the options at the end of life are paramount and central to this bill, we are also placing upon medical practitioners obligations that will violate their conscience and take away their right to conscientiously object. Clause 4, “Principles”, and clause 9—the quite overt reference to the right of medical practitioners to be conscientious objectors—are contradicted by clause 19(5)(b). Medical practitioners who have a conscientious objection to voluntary assisted dying will be forced—compelled—to provide information in contravention of perhaps deeply held religious or cultural beliefs.

My amendment addresses not just this infraction but also the concerns I raised earlier—that a medical practitioner who is otherwise unwilling to perform the duties of a coordinating practitioner will still be obliged to provide information. It is my belief that that will cover medical practitioners who know that their patient is ineligible or know that it would be inappropriate if their patient were to seek voluntary assisted dying in the instance that their patient is under the age of 18 years or is suffering from a mental illness or some other cognitive impairment. By deleting lines 19 to 26 on page 15 and inserting a new clause 19(5) that reads, “If the medical practitioner refuses the first request under subsection (2)(a)”, rather than the current reference to conscientious objectors, my amendment will ensure that any medical practitioner who objects or refuses under subclause (2)(a)—that being conscientious objectors or medical practitioners otherwise unwilling to perform the duties—will be protected from the obligation to provide information to a patient. There is still an obligation for them to inform the patient immediately of their refusal to carry out those duties. The patient is to be advised that the medical practitioner will not carry out the duties, but there is no obligation to provide the information. This amendment will ensure that medical practitioners are not put in that difficult situation of having to violate their conscience or provide information that they think may be harmful to a patient. It is consistent with the Victorian legislation. It is consistent with the Oregon legislation. It is consistent with the principles of liberalism. It is consistent with the principles of this bill as stated in clause 4—that autonomy should be respected, the religious and cultural views of individuals should be respected and people should not be coerced. I commend this amendment to the chamber.

Hon ALISON XAMON: In response to the amendment that has been presented, I go back to clause 19(2)(a) of the bill. It is important that we note that subclause (2)(a) is split into two different parts; one part refers to conscientious objection and the other part refers to being otherwise unwilling to perform the duties of a coordinating practitioner. The reason that is important to note in relation to this amendment is that subclause (5) refers only to the requirement to give information in the event of a conscientious objection. It is important to note that the bill currently refers to a scenario in which a practitioner is otherwise unwilling to perform the duties of a coordinating practitioner. That could well be a situation in which a practitioner is of the view that someone is at risk, is experiencing psychosis, is six years old or is clearly not dying. We could envisage a whole range of scenarios in which it would be not only inappropriate, but also potentially patently absurd for the GP to be obliged to supply that information. As I understand the minister’s response previously, if someone were to issue a complaint that the information had not been issued in those circumstances, that complaint would be unlikely to be upheld. It is important to make that distinction, because then the existing provision that the amendment seeks to amend would apply only to people who are unwilling to supply the information because they have a conscientious objection. I think the conscientious objection provision within this legislation is an important one and one that we should be absolutely prepared to protect and uphold. It is reasonable. In fact, I have not heard anybody argue against the capacity for a medical practitioner to exercise a conscientious objection to this piece of legislation. However, it says that the medical practitioner cannot just advise that they object and leave it at that, with no capacity for a patient to have any idea about where they might be able to go after that. This is not an uncommon provision in other conscientious objection regimes. For example, with teenage pregnancies and those sorts of things, people are not obliged to engage in particular procedures if they do not wish to, but nor should people be left without any idea about the options that are potentially available to them if they go elsewhere.

It is important to note that the amendment refers to the medical practitioner refusing the first request under subclause (2)(a), and that is broader than the current requirement in the bill to provide information. I wanted to at least make sure that members were aware that it is potentially imputing a requirement to give information that I am not sure currently exists within the entirety of subclause (2)(a).

Hon AARON STONEHOUSE: In response to the remarks by Hon Alison Xamon, I point members to clause 19(4), which states —

Unless subsection (5) applies, —

That is the conscientious objector provision —

the medical practitioner must, within 2 business days after the first request is made —

- (a) inform the patient that the practitioner accepts or refuses the request; and
- (b) give the patient the information approved by the CEO for the purposes of this section.

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Under subclause (2)(a), if the medical practitioner is otherwise unwilling to perform the duties of a coordinating practitioner, subclause (4)(b) will come into effect and they will have to provide that information. My amendment focuses on subclause (2)(a) in its entirety, rather than just the conscientious objector provision, which is currently referred to in subclause (5). The reason I have done that is that although I originally intended to protect the rights of conscientious objectors, as I have teased out this issue of objections under subclause (2)(a), I have become concerned about the lack of discretion afforded to medical practitioners who are unwilling, for some ethical reason rather than a conscientious objection, to carry out the duties of a coordinating practitioner because they know that their patient is vulnerable, at risk of harm, patently ineligible or things of that nature. I am providing a broader protection for all objections under subclause (2)(a). It is intentional and I think it is appropriate.

I am mindful of the comments made by the minister about a breach of obligations under subclause (4)(b) if a six-year-old walked into a medical practice and asked for access to voluntary assisted dying and the doctor said, “Get out of here; that’s silly.” If that were taken to the professional board that oversees the conduct of medical practitioners, the board would assess the circumstances and a reprimand would probably not be involved. In an example like that, it probably would not involve a reprimand, but I am very uncomfortable with the idea of leaving it to some external body to determine the circumstances in which it may be appropriate or inappropriate for a medical practitioner to refuse to provide information under subclauses (4)(b) or (5)(b). There may be situations that are not so black and white and are quite nuanced. It is essential that we provide clear protection to medical practitioners in this instance and make it very clear to them what their rights and obligations are. If we say to medical practitioners, “Use your discretion and maybe your oversight board will determine whether you acted appropriately”, I do not think that is an appropriate way to legislate. I do not think that will provide adequate comfort to medical practitioners in the future when they are trying to determine what their obligations are. My amendment very clearly states that any refusal under subclause (2)(a) will not trigger an obligation to provide information. I think it is very appropriate.

By retaining the obligations under subclause (5)(b), we are saying to people who have deeply held religious or cultural beliefs—they may be Christian, Muslim, Sikh or what have you—that even though they have a moral objection to voluntary assisted dying, they will be compelled by the state to participate in that regime. I know that members will say that they do not have to be the coordinating practitioner, but providing comprehensive information about how people can access voluntary assisted dying is being involved in the regime. I am sure that it is not hard for members to imagine a scenario in which there is something that they find morally objectionable that they would not do or facilitate themselves, but if they were forced to provide information to somebody who asked them about it, they would find that a breach of their conscience—something that gets them involved in a process that they find morally objectionable. Are we willing to compel medical practitioners to do that? I do not think we should. In a western, liberal democracy, in which we are passing a bill central to which is the autonomy and rights of an individual to make choices for themselves about their own health care at their end of life, it would be reprehensible to include in that legislation obligations that violate the conscience of medical practitioners.

I really want members to think carefully about that. If that is what they want to do, I guess I cannot convince them otherwise, but they should not be kidded. This will involve putting an obligation on medical practitioners with conscientious objections to voluntary assisted dying to provide information.

Hon MARTIN PRITCHARD: As a side point, in a previous clause we debated and allowed for doctors to be able to initiate the discussion on VAD. During that debate, I raised the concern that it did not mandate that the doctor had to raise it, so many patients would be unaware of voluntary assisted dying and many doctors would not raise it because of their conscientious objection or other reasons. I said at the time that during the implementation stage, the department would need to put together a strategy for people to learn about voluntary assisted dying. I make that point again. I am sympathetic to the amendment and think it behoves the department to make sure that people are aware of voluntary assisted dying and can access information.

Hon JACQUI BOYDELL: I will not be supporting the amendment for a couple of reasons. I think it comes with the premise that providing information is participating. I do not agree with that principle or that that is the case. I have always believed that doctors have an obligation to inform patients of their options. A medical practitioner who is a conscientious objector simply provides information to a patient who asks about voluntary assisted dying, and that does not mean that they are participating in the potential voluntary assisted dying plan for that patient. If doctors want to be conscientious objectors, they will have no role, apart from handing over information to patients. I do not believe a medical practitioner who is a conscientious objector will be in a position to be able to make an assessment about whether a patient is or should be eligible for voluntary assisted dying because they have decided to opt out. It is not their call to make. If doctors want to be conscientious objectors, I completely respect that, but that means that they do not get to make any assessments about whether patients should be eligible. They get to hand over information to the patient, allow the patient to read the information, determine whether they may be eligible and seek further consultation. Just because patients have the information does not mean that they will

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continue the process or will participate in any way. If patients get the information and determine that they want to seek out a medical practitioner who may be able to assist them, they will still have to go through the process and at that point the assessment of their eligibility will be made. That they got the information from a doctor who was a conscientious objector has nothing to do with the fact that they may access the scheme.

From a regional perspective, if the bill should pass the house, regional patients will need a process to protect them and give them access to voluntary assisted dying, because if the one doctor in their town is a conscientious objector and the fundamental information that patients require would not be available anywhere else, that would create a roadblock for regional patients. I have always been concerned about that. For those reasons, I do not support the amendment as put.

Hon RICK MAZZA: I have been weighing up two things when thinking about this amendment. The first is the idea of someone going to their medical practitioner and that medical practitioner having a conscientious objection or being unwilling to discuss voluntary assisted dying with them and being sent away with no pamphlet or information. The second is that if the medical practitioner does not provide information and a complaint is made to a standards board, they will be at the mercy of the standards board as to whether they will be prosecuted, for want of a better word. That seems a little open-ended to me as a legislator. What the penalty would be for that medical practitioner is not clear enough. If they were to be suspended or have a severe penalty put on them, it could impact them greatly. Weighing those two things in my mind—a patient being sent away without information, or a medical practitioner having a complaint made against them and, I think, unjustly, receiving a penalty for that—I err on the side of supporting this amendment. It is a little concerning to me in some ways that this clause does not cover off situations in which medical practitioners do not provide the information clearly. If it did, I would probably be likely not to support the amendment and think that the patient should be given some information before being sent away. On that basis, I will be supporting the amendment.

Hon NICK GOIRAN: This bill refers to a request and assessment process. That is referred to a few times in the bill, including under clause 8, which tells us when the request and assessment process is completed. Is a medical practitioner's decision to accept or refuse a first request part of the request and assessment process?

Hon STEPHEN DAWSON: The honourable member asked the very same question at clause 9. In fact, a lot of what has been raised in this clause this evening was raised under clause 9. We had quite an extensive debate at clause 9, so I do not propose to re-answer questions that were asked at clause 9 now. I do not propose to go into the same level of detail we went into at clause 9, but I will comment on some things that have been raised. I draw members' attention to the report of the Ministerial Expert Panel on Voluntary Assisted Dying. On page 52, under the heading "Personal objection", it states —

If legislation is passed to enable voluntary assisted dying in Western Australia the panel noted the relevance of the principle that a person should not be impeded in accessing what would be a legal option at end of life. In the Panel's view however, it is not sufficient to simply not impede access.

A little later it continues —

... the Panel determined that the most appropriate option was to recommend that practitioners and services that have a conscientious objection have an obligation to provide information to people seeking voluntary assisted dying but are not obliged to refer on. This would appear to be an acceptable 'middle ground'.

The provision of information balances the right of a doctor to conscientiously object and the right of a patient to be properly informed. The bill reflects that this balance should favour the patient in these circumstances. It is also consistent with current professional obligations. I have already given reasons for the different timing requirements for practitioners, so I am not going to go over that again. I reiterate that this is in line with the Australian Medical Association's position on conscientious objection. I have read that before, but I will bring it to members' attention again. Its position statement states —

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

Hon NICK GOIRAN: For starters, minister, that is talking about care being provided to a patient, not a pathway to death. There is a very big difference between a medical practitioner who has a conscientious objection being required to send information to a patient to care for them and sending them on a pathway to death. I find it appalling to try to use that as the justification for that. By the way, the reason I asked that question earlier—as to whether this is part of the request and assessment process—is that Hon Jacqui Boydell has just passionately put to us that this has nothing to do with participating in the process. According to the minister's own bill, providing information

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is part of the first request, and the first request is part of the request and assessment process. I was just trying to clarify that for the honourable member, who seemed to be under the misapprehension that by providing information, one is not actually participating in the process. That is not what the minister's bill says, but I understand that he is not willing to answer that question. I am not at all persuaded by the non-answers that have been provided this evening. I hold the view that if it is good enough for the Victorian doctors, it should be good enough for the Western Australian doctors. I do not see why our Western Australian doctors should be treated like second-class citizens. I also find it quite ironic that we 36 members have a conscience vote, but we are not prepared to provide the same conscience right to medical practitioners in Western Australia.

Division

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

Ayes (7)

Hon Nick Goiran	Hon Simon O'Brien	Hon Aaron Stonehouse	Hon Ken Baston (<i>Teller</i>)
Hon Rick Mazza	Hon Charles Smith	Hon Colin Tincknell	

Noes (26)

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

Amendment thus negated.

Clause put and passed.

Clause 20: Medical practitioner to record first request and acceptance or refusal —

Hon AARON STONEHOUSE: Clause 20 deals with an obligation on medical practitioners to record the first request and acceptance or refusal. Just to be absolutely clear, that obligation exists regardless of whether a medical practitioner has refused a request under clause 19(2)(a), (b) or (c); is that correct?

Hon STEPHEN DAWSON: Yes.

Hon AARON STONEHOUSE: I assume that if it is during the course of a medical consultation, as amended clause 17 now reads, a medical practitioner would presumably have access to a patient's medical record; is that correct?

Hon STEPHEN DAWSON: Each patient has their own medical record. They do not have access to the medical records of another practitioner.

Hon NICK GOIRAN: Under clause 20(d), why is it assumed that the practitioner might not have given the patient the information referred to? It seems to indicate that they might have provided it, but they might not have provided it, yet at clause 21(2)(g), it is assumed that the patient has been provided the information. Why the distinction?

Hon STEPHEN DAWSON: At the time of the medical consultation at which the first request has been made and has been documented, under the clause, the practitioner may not have given them the information yet, as they may have two days to give it to them, as per clause 19(4). Clause 20(d) can be a reminder to the practitioner about what they have to do.

Hon ADELE FARINA: Could the minister clarify whether the medical practitioner is required to record in the My Health Record for the patient any of this information that they are required to record?

Hon STEPHEN DAWSON: The bill does not require it.

Clause put and passed.

Clause 21: Medical practitioner to notify Board of first request —

Hon NICK GOIRAN: Is a conscientious objector obligated to comply with clause 21?

Hon STEPHEN DAWSON: The answer is yes.

Hon NICK GOIRAN: How so, in light of clause 9?

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

Hon STEPHEN DAWSON: They need to fulfil the requirements of the first request. This includes reporting to the board. I think that this point has been canvassed at an earlier stage of the debate.

Hon NICK GOIRAN: When we supposedly had a discussion at an earlier part of the debate, the minister indicated that the specific overrides the general. I think the minister said that to the chamber. Clause 19 is very specific about conscientious objection, whereas clause 21 is entirely silent. In those circumstances, given that there is no specific requirement for conscientious objectors under clause 21, on what basis are we now saying that there is a specific requirement that overrides the general provision at clause 9, specifically when clause 9(2) states —

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

Hon STEPHEN DAWSON: There is operational continuity between clauses 19, 20 and 21. It clearly applies to practitioners under clauses 19 and 20.

Hon AARON STONEHOUSE: The obligation in clause 21 for a medical practitioner to notify the board of a first request would apply in those circumstances that I described earlier when we discussed clause 19—that being a situation in which a child may make a request to a medical practitioner. A medical practitioner would be obliged to fill out the first request form and record information such as name, date of birth, the contact details of the patient, the name and contact details of the medical practitioner, the date when the request was made and so on. That same obligation would exist for other people who may be, on the face of it, potentially eligible, but it seems to me to be a little absurd that in those instances in which a patient is clearly ineligible—someone under age—a medical practitioner would still be obliged to fill out that form. That is not a question; it is merely an observation. Some of these obligations might be a little too rigid and do not allow medical practitioners to use their discretion in these instances.

If it is helpful to clear it up for other members, there is an amendment to clause 21 in my name on the supplementary notice paper. That is a consequential amendment to the amendment I moved to clause 19. As my amendment to clause 19 was unsuccessful, I do not intend to move my amendment 14/21.

Hon NICK GOIRAN: Is the amendment on the supplementary notice paper at 14/21 consistent with clause 20(d)?

Hon STEPHEN DAWSON: Sorry, honourable member, but we were having a debate about the question. Would you mind asking the question again, please?

Hon NICK GOIRAN: Is the amendment standing on the supplementary notice paper at 14/21 consistent with clause 20(d)?

Hon STEPHEN DAWSON: I am advised it is not consistent, but it does not need to be, because the obligation to provide the information should have been complied with before notification to the board.

Hon NICK GOIRAN: If the minister looks at clause 21(2)(g), he will see that it refers to the practitioner needing to provide —

the date when the medical practitioner informed the patient of the practitioner's decision and gave the patient the information referred to in section 19(4)(b);

Could that not happen on two different dates?

Hon STEPHEN DAWSON: Yes, it could be two different dates.

Hon NICK GOIRAN: Would the amendment standing in the name of Hon Aaron Stonehouse at 14/21 not be superior to the current provision at clause 21(2)(g), which conflates the two requirements into one date, whereas Hon Aaron Stonehouse's amendment separates them out?

Hon STEPHEN DAWSON: I am advised that Hon Aaron Stonehouse's amendment does not include the date requirement; our clause does, and allows for different dates to be recorded. This will be provided for at implementation.

Hon NICK GOIRAN: I move —

Page 16, lines 24 and 25 — To delete the lines and substitute —

patient of the practitioner's decision;

(ga) the date when the medical practitioner gave the patient the information referred to in section 19(4)(b);

The DEPUTY CHAIR: That is slightly different from the amendment on the supplementary notice paper. We will get that distributed.

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

Hon STEPHEN DAWSON: The government is of the view that the current provision in the bill is clearer. As I have said, if the date is different, this will be recorded, and the change is not required.

Hon NICK GOIRAN: The provision currently reads —

the date when the medical practitioner informed the patient of the practitioner's decision and gave the patient the information referred to in section 19(4)(b);

Is the minister saying to the chamber that that provision is clearer than a provision that separates out the two and specifies that there is a possibility that there will be different dates between the two? I am staggered if it is seriously the advice to the chamber that clause 21(2)(g) is clearer than the amendment that I have proposed.

Hon AARON STONEHOUSE: I have been convinced of the importance of the amendment that I had on the supplementary notice paper, albeit now with slightly different wording—it does seem to provide some clarity. However, I am interested to hear what the minister has to say in response to the point just made by Hon Nick Goiran. At this point, I view the amendment favourably.

Hon STEPHEN DAWSON: My advice stands. I am advised that, as it reads, the date applies to both limbs.

Division

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

Ayes (7)

Hon Martin Aldridge
Hon Rick Mazza

Hon Martin Pritchard
Hon Charles Smith

Hon Aaron Stonehouse
Hon Colin Tincknell

Hon Nick Goiran (*Teller*)

Noes (28)

Hon Ken Baston
Hon Jacqui Boydell
Hon Robin Chapple
Hon Jim Chown
Hon Tim Clifford
Hon Alanna Clohesy
Hon Peter Collier

Hon Stephen Dawson
Hon Colin de Grussa
Hon Sue Ellery
Hon Diane Evers
Hon Donna Faragher
Hon Adele Farina
Hon Laurie Graham

Hon Colin Holt
Hon Alannah MacTiernan
Hon Kyle McGinn
Hon Michael Mischin
Hon Simon O'Brien
Hon Samantha Rowe
Hon Robin Scott

Hon Tjorn Sibma
Hon Matthew Swinbourn
Hon Dr Sally Talbot
Hon Dr Steve Thomas
Hon Darren West
Hon Alison Xamon
Hon Pierre Yang (*Teller*)

Amendment thus negatived.

Clause put and passed.

Clause 22: Medical practitioner becomes coordinating practitioner if first request accepted —

Hon NICK GOIRAN: Can a medical practitioner refuse to continue to participate in the assessment process once the practitioner has accepted the patient's first request and formally become the coordinating practitioner under clause 22?

Hon STEPHEN DAWSON: The answer is yes, but they would need to transfer the role according to clause 155.

Hon NICK GOIRAN: Clause 155 refers to the transfer of a coordinating practitioner's role. Is that based upon—no; the minister will tell me to discuss that at clause 155! That is fine; I will rephrase the question. Will a medical practitioner face disciplinary or legal action if they refuse to continue to participate in the assessment process after being recognised as the coordinating practitioner under clause 22?

Hon STEPHEN DAWSON: The answer is no; they would not be sanctioned.

Hon NICK GOIRAN: The minister indicated that if a medical practitioner wants to refuse to continue to participate in the process, they could transfer under clause 155. However, clause 155 allows only for the transfer of the coordinating practitioner to happen if the consulting practitioner consents. Does that mean that a coordinating practitioner is stuck and forced to continue to be a coordinating practitioner even if they have some concerns for some reason? Maybe the patient says that their request is enduring but the coordinating practitioner does not think that it is enduring, or maybe the patient develops a new condition that the patient did not suffer at the time. It could be for any reason. Maybe the practitioner suddenly has a change of heart and has a conscientious objection, or is unwilling to participate in any way. Will coordinating practitioners be stuck, with no capacity to refuse to continue to participate?

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

Hon STEPHEN DAWSON: I am advised that they can object at any stage of the process, but it may mean that the patient will need to find another coordinating practitioner.

Hon NICK GOIRAN: That is indeed good news. What part of the bill makes it clear that the practitioner can object at any stage?

Hon STEPHEN DAWSON: It is under clause 9.

Clause put and passed.

Clause 23: First assessment —

Hon NICK GOIRAN: Clause 23 is silent on the time frame within which the first assessment must be made by the coordinating practitioner. Must the assessment be made in one consultation or can the coordinating practitioner make their assessment over several consultations with the patient?

Hon STEPHEN DAWSON: It can be over several consultations.

Hon NICK GOIRAN: What evidence can the coordinating practitioner take into account in assessing whether the patient meets all the eligibility requirements under clause 15? Members will see at clause 23(2) —

... the coordinating practitioner must make a decision in respect of each of the eligibility criteria.

What evidence can they take into account in making that assessment? For example, will the coordinating practitioner have access to all the patient's medical records?

Hon STEPHEN DAWSON: It is any relevant information such as medical history, and they can seek specialist reports or other reports from other health practitioners.

Hon NICK GOIRAN: I move —

Page 17, line 12 — To delete “criteria.” and substitute —

criteria and take into account the medical history of the patient.

This amendment proposes to mandate in clause 23 that a coordinating practitioner must take into account a patient's medical history when making the decisions about each of the eligibility criteria set out in clause 15 of the bill. Unfortunately, we cannot legislate to cover every issue that will arise as this legislative scheme becomes operational in medical practice in our state. As serious legislators, with foresight we can anticipate when issues might arise and address them as best we can. It is instructive to consider the debate that took place in the other place on 4 September 2019 when the member for Cottesloe and the member for Darling Range identified an issue in the bill that we now have an opportunity to address. The dialogue took place as follows —

Mrs A.K. HAYDEN: In case I have missed it, is there an obligation for the doctor to seek the medical history of a patient when determining the decision-making capacity of that individual?

Mr R.H. COOK: It is not a subject of this clause, but it is obviously a significant part of a medical practitioner's clinical and legal obligations as a clinician.

Mrs A.K. HAYDEN: Before we move on from that, can we ask this question in another part of the legislation? Is the minister prepared to answer that now or does he want us to come back to it? I do not want to move on from this clause if it cannot be discussed later.

Mr R.H. COOK: It is not part of the bill. It is part of good clinical practice and, of course, the obligations that medical practitioners are required to practise under, in relation to the law and registration with the Medical Board of Australia.

Mrs A.K. HAYDEN: So that I have it right—I do not want to misquote the minister—under the decision-making capacity provision in clause 6, the doctor is not obliged to seek the medical history of a patient to determine whether they have the capacity to make that decision. I want to clear that up.

Mr R.H. COOK: A medical practitioner is required to draw upon their medical practitioner training, experience and skills to make that assessment. Obviously, they would take the full range of information available to them, including the medical records of the patient.

Mrs A.K. HAYDEN: I have one last question because I know the member for Cottesloe wants to ask something on this clause as well. Is it in the Victorian legislation?

Mr R.H. COOK: I am advised that it is not.

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

Dr D.J. HONEY: I want to clarify that, because I was not reassured by those words. We have these general words that it would be good practice, but the question that was very specifically asked is whether there is an obligation under this act for them to do that. We have heard the member for Girrawheen talk about a patient with dementia or some other degenerative illness that may not be readily apparent to someone, even a medical practitioner, when talking to or meeting that patient for the first time. It is all right saying that it is good practice or it is good clinical practice but, specifically, is there an obligation under this bill for a doctor to do that? I guess a corollary of that is—I will not draw this out into 20 questions—how would anyone know whether they had done that? The very specific question is not, “Is it good practice?” but “Is there an obligation under this bill, and how would anyone know whether they had done that?”

Mr R.H. COOK: As the member knows, we rely upon medical practitioners to make decisions and conduct themselves in specific ways as a matter of Australian law under the conditions associated with their Australian Health Practitioner Regulation Agency registration. They have ethical, legal, professional and moral obligations to undertake all these practices. It is not prescribed in this legislation but it is implicit in the use of a medical practitioner in this role and it is explicit in the national health professions law.

Dr D.J. HONEY: To complete the second part of the question, how would anyone know whether that had been done?

Mr R.H. COOK: In the same way that we can be assured that anyone receiving clinical care receives that care within the appropriate legal framework.

Dr D.J. HONEY: I do not wish to verbal the minister at all but that response was general and generic. We either have a mechanism to know that that has been done or we do not. I do not think we can ever say that we know because we assume it would be done as best practice. I take it from the minister’s answer that we do not have any way of knowing whether that has been done. We can only assume that it was done.

Mr R.H. COOK: A medical practitioner will have to make declarations on the authorised forms throughout the voluntary assisted dying process. They might lie on those forms.

Dr D.J. Honey: I’m not worried about lying.

Mr R.H. COOK: That is right. All those declarations and authorisations on the authorised form will obviously take into account that they have discharged their duties and there would have to be a declaration around that. That is how we would know, and obviously the Voluntary Assisted Dying Board will see those as part of the voluntary assisted dying processes. Yes, there will be declarations and certifications and they will be part of the assessment process.

We can see from the debate in the other place that this issue was identified by those members in that dialogue with the Minister for Health. Unless something has changed or the position of government has evolved, it is clear that that particular provision is not in the bill. It is my proposition to members that rather than leaving it to best clinical practice, it would be superior for us to mandate that a practitioner should take into account the medical history of the patient; not the least of which because we know from the lived experience in the Northern Territory, during the short time that that legislation was in place there, that there were patients who had a history of depression and the like and Dr Philip Nitschke ran around making voluntary euthanasia available for those patients notwithstanding that medical history. I think it would be a superior provision to mandate it in the legislation rather than simply leaving it to best clinical practice on the bold assumption that every medical practitioner in Western Australia is going to adhere to best clinical practice.

Hon STEPHEN DAWSON: I indicate to honourable members that the government is not supportive of the amendment that stands in Hon Nick Goiran’s name. I draw the chamber’s attention to an amendment standing in my name on page 5 of the supplementary notice paper at 459/23. The proposed amendment in my name makes it clear that the coordinating practitioner, when making the first assessment, can consider and rely on relevant information about the patient from a registered health practitioner. This clause has been included following consultation with the Western Australian branch of the AMA, and the government considers this to be a good amendment. This is to reflect that although the assessing practitioner must have regard to their own skills and training when determining the eligibility criteria, they should also rely, as part of their assessment, on contemporary and relevant health information; for example, a medical report containing a clinical diagnosis. Of course this is already something that medical practitioners can and will do as part of good clinical practice. The clause that stands in my name is phrased wider than “medical history”; it includes any other health reports or specialist reports that a patient may have.

Hon Stephen Dawson; Hon Robin Chapple; Hon Rick Mazza; Hon Adele Farina; Hon Peter Collier; Hon Nick Goiran; Hon Martin Pritchard; Deputy Chair; Hon Aaron Stonehouse; Hon Alison Xamon; Hon Colin Tincknell; Hon Tjorn Sibma; Hon Colin Holt; Hon Michael Mischin; Hon Charles Smith; Hon Jacqui Boydell

Hon NICK GOIRAN: That is true, and to that extent there is an attraction to the amendment standing in the minister's name. Is it not the case that the minister's amendment at 459/23 does nothing more than state what is already the case?

Hon STEPHEN DAWSON: My amendment makes it clear that practitioners are not being limited by this bill.

Hon NICK GOIRAN: There is nothing in the bill that suggests they are being limited, so of course a practitioner can have regard to other information. That goes without saying; we do not need 459/23 to tell us that. The difference with the amendment standing in my name is that it requires the practitioner to take into account the medical history of the patient. The minister's amendment simply says that a medical practitioner can have documents at their disposal and nothing stops them from looking at them if they want to. My amendment says we want them to pick them up and look at them and ask whether the patient has a history of depression or a history of some other issue that the practitioner should take into account. My amendment creates an obligation on the practitioner, whereas the minister's states something that already exists. It would already be the case, minister, that the practitioner can take into account any of that information.

Hon PETER COLLIER: To assist in this process, can the minister confirm that as a result of the communication that took place with the AMA with regard to this amendment, the president of the AMA will be part of the implementation board and he will have input into the guidelines that will be established, which will have a direct impact on the information that will be available to practitioners? That will go a long way towards assisting in the information that will be available. Can the minister confirm that? I do not want to verbal the minister at all, but as I understand it, that was part of the discussions that took place between the minister and the AMA.

Hon STEPHEN DAWSON: Thank you, honourable member. I can confirm that the AMA WA president, or their nominee, will be part of the group responsible for developing the guidelines and processes for voluntary assisted dying.

Hon NICK GOIRAN: Will it be a requirement in those guidelines that the practitioner needs to take into account the medical history of the patient?

The DEPUTY CHAIR: Noting the time and the consideration that is going on, I might allow the minister to consider that overnight. I will report progress.

Progress reported and leave granted to sit again, pursuant to standing orders.