VOLUNTARY ASSISTED DYING BILL 2019

Committee

Resumed from 27 November. The Deputy Chair of Committees (Hon Matthew Swinbourn) in the chair; Hon Stephen Dawson, (Minister for Environment) in charge of the bill.

Clause 42: Witness to signing of written declaration —

Progress was reported after the clause had been partly considered.

Clause put and passed.

Clause 43: Certification of witness to signing of written declaration —

Hon NICK GOIRAN: Under clause 43(2) a witness must make a declaration that the patient appeared to freely and voluntarily sign the declaration. Section 36 of the Victorian legislation, the equivalent to our clause 43, goes further by requiring that the witness declared that the patient also appeared to have decision-making capacity in relation to voluntary assisted dying and that the patient appeared to understand the nature and effect of making the declaration. Why does the bill not include the declarations relating to capacity and understanding at this clause?

Hon STEPHEN DAWSON: I am advised that is not appropriate to expect laypersons to make those assessments. It is for trained coordinating or consulting practitioners to do so.

Hon NICK GOIRAN: How might a witness determine that a patient appears to be freely and voluntarily signing a declaration? What factors would a witness take into account in making this assessment?

Hon STEPHEN DAWSON: On clause 43, the explanatory memorandum states —

> The purpose of the declaration is to reflect the voluntary and enduring nature of the patient's request for access to voluntary assisted dying. The purpose of the two witnesses is to provide independent verification that the written declaration was signed freely and voluntarily by the patient.

They should be able to see whether the patient looks stressed or pressured, and they should be able to tell that no-one is coercing or standing over the patient.

Hon NICK GOIRAN: Should they also be able to appreciate whether the patient appears to understand that they are making the declaration?

Hon STEPHEN DAWSON: It is not for them to judge comprehension. That is why we have the separate assessment process.

Hon NICK GOIRAN: Given that these requirements are in section 36 of the Victorian legislation, upon whose advice was it decided to eliminate these particular safeguards?

Hon STEPHEN DAWSON: It was a government decision. I will make the point that Western Australia has not slavishly followed the Victorian example or the Victorian bill. A discussion did happen at the Ministerial Expert Panel on Voluntary Assisted Dying. Page 67 of the final report notes —

> In relation to witnessing provisions, the Panel noted advice from Victoria that their provisions were potentially complex in implementation and that Western Australia should aim to strike a balance between safeguards and practicality in this regard and wherever possible to base these provisions on an existing practice.
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> The Panel determined that the written declaration should be witnessed by two witnesses to attest that the person requesting voluntary assisted dying signed the declaration voluntarily. The witnesses would be people who are aged 18 or over and have no reasonable grounds for belief that they will benefit financially from the person's death.

Hon NICK GOIRAN: I agree with the minister. It is clear that the government has not slavishly followed the Victorian legislation. The government has removed several significant safeguards that are in the Victorian legislation. Two of those safeguards are the ones that we have just outlined, and of course members will be familiar with the safeguards that have been eliminated—the mandatory requirement that a specialist be involved, and prohibiting a doctor from initiating the conversation with the patient. Therefore, I agree with the minister entirely that the government has not slavishly followed the Victorian legislation. Perhaps where we differ is that, in my view, it is now verifiably the case that this legislation is less safe than the Victorian legislation.

Clause put passed.

Clause 44: Coordinating practitioner to record written declaration —

Hon NICK GOIRAN: Will the board have access to the clause 44 record in the patient's medical record for the purpose of monitoring the operation of the bill, or if the board holds concerns that the correct process has not been followed by the medical practitioner?

Hon STEPHEN DAWSON: I am told the board can request the information to assist in performing its functions. That is clause 149.

Hon NICK GOIRAN: Sorry, minister; there was some noise then. Did you say clause 140?

Hon Stephen Dawson: Clause 149.

Hon NICK GOIRAN: Very good. How long are these medical records required to be kept?

Hon STEPHEN DAWSON: It is generally seven years. There might be a slight difference between private hospitals and public hospitals, or private medical services and public medical services. It is seven years for the state and it could be between seven and 10 years for private services.

Clause put and passed.

Clause 45: Coordinating practitioner to notify Board of written declaration —

Hon NICK GOIRAN: What is the board required to do with this notification under clause 45?

Hon STEPHEN DAWSON: The intent of the provision is to ensure that the board is able to ensure that the correct process is followed in each case of voluntary assisted dying. Further, the clause enables the board to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: However, the board will not know about it. The board will catch the form supposedly within two business days, but of course it might not receive it within two business days, so how can it then know whether the process has been complied with? It will not know when the written declaration was made. The provision says that within two days of the written declaration having been made, the coordinating practitioner has to give a copy of the form to the board. The board will have no idea of the date of the written declaration until it receives the form. What is its role in this particular instance, when it catches the form?

Hon STEPHEN DAWSON: The onus is on the doctor to do this. The board has a simple monitoring role in this regard.

Hon NICK GOIRAN: To monitor what, minister? Is it to monitor whether the practitioner has provided the form within the two business day? Is that the only thing the board will do? Will it look at when the written declaration was made and when the board received the form and check whether it was within two business days; and, if it was not, will it potentially get the CEO to prosecute the practitioner? Will it otherwise perform no other role with regard to this form? It seems to be merely a function to facilitate prosecution of a medical practitioner.

Hon STEPHEN DAWSON: The form will evidence that the written declaration has been given before the final review. It is a declaration that confirms that the patient wants to continue in the voluntary assisted dying process. I previously mentioned that the clause enables the board to maintain complete and accurate statistics of participation in voluntary assisted dying, so there is that element of capturing statistics, too.

Hon NICK GOIRAN: Will the board also ascertain whether any of the witnesses were ineligible?

Hon STEPHEN DAWSON: No, it will not, but if somebody makes a complaint, it could.

Clause put and passed.

Clause 46: Patient may make final request to coordinating practitioner —

Hon NICK GOIRAN: Will a clause 46 final request made via clause 156(2)(a) be affected in any way by sections 474.29A and 474.29B of the commonwealth Criminal Code Act?

Hon STEPHEN DAWSON: The final request is initiated by the patient, so no.

Hon NICK GOIRAN: The coordinating practitioner knows that the next step that needs to be taken by their patient—let us say it is a regional patient—is to make a final request. What happens if the doctor initiates the audiovisual technology with a carriage service, maybe by phone or Skype or some other facility? I cannot see that a patient, who will probably not be that familiar with this process, is likely to say, "We're up to section 46 in the process and it's my job as the patient who has a terminal illness to realise that I now need to ring my coordinating practitioner and let them know I would like to make a final request." I think that is quite unlikely. I think it is far more likely that the coordinating practitioner would initiate the phone call and use the carriage service. Would that make any difference in respect of this provision and its intersection with commonwealth law?

Hon STEPHEN DAWSON: The medical practitioner will not be prompting the patient to make a final request, but who does the dialling will not make a difference. In this case, a patient making a final request is not breaching the commonwealth provisions.

Hon NICK GOIRAN: I realise the patient might not be, but would the medical practitioner be?

Hon STEPHEN DAWSON: He is just receiving a request, so no.

Clause put and passed.

Clause 47: When final request can be made —

Hon NICK GOIRAN: This is a very interesting clause. It refers to when the final request can be made. Could the final request be made more than six months after the written declaration?

Hon STEPHEN DAWSON: There is no specified time limit between the written declaration and the final request, but clause 46 states that the final request must be clear and unambiguous.

Hon NICK GOIRAN: In my view, this is a real problem. Let us look at the Oregon experience, which has had this regime for more than 20 years. The patient has to have a prognosis of six months to live. Our bill also says six months but in certain situations it is 12 months. Interestingly, during the first 17 years of data in Oregon, the longest recorded time between the initial request and the ingestion of the lethal drug was 1 009 days. In case members think that is an isolated incident, in 2015, the longest recorded period was 517 days. In four of the 17 years between 1998 and 2015, there was at least one case in which the duration between the initial request and the ingestion was more than two years. I think this is a point of real concern that we are saying that the doctor has said this patient is going to die within six months, yet we will leave open the possibility of the patient making the final request more than six months after they have signed the written declaration. The very fact that they are making that request more than six months after the written declaration would be evidence that the prognosis by the doctor was wrong. Surely the board should intervene and investigate, rather than allowing that to continue to take place. Would the board investigate that situation?

Hon STEPHEN DAWSON: I am advised that it is possible that it could refer it for investigation.

Hon NICK GOIRAN: There should be a cap. A safeguard should be implemented here, minister, but that is to do with the outer end of the request process, but clause 47 also allows the process to be accelerated. It says that it cannot happen any sooner than nine days, other than in certain specified circumstances. For many insurance policies, for example, 14 days is not an unusual cooling-off period and in Oregon the period is 15 days. Another legislature that has assisted dying is Hawaii and it has 22 days. Why was nine days selected by the government in this instance?

Hon STEPHEN DAWSON: It was recommended by the ministerial expert panel after considering the various time frames used in different jurisdictions around the world.

Hon NICK GOIRAN: The minister says that it was recommended by the ministerial expert panel. Can the minister draw to our attention the panel's analysis of the different jurisdictions and why it concluded nine days?

Sitting suspended from 1.00 to 2.00 pm

Hon STEPHEN DAWSON: Before the break, Hon Nick Goiran had asked a question about the nine-day period outlined in the bill. That nine-day period is the same as in Victoria. It is dealt with in the ministerial expert panel's report from page 69 to 71. The section titled "Reflecting on the decision" at page 69 of the MEP final report deals with these considerations.

Hon NICK GOIRAN: I notice that at page 71 of the ministerial expert panel's report it states that the period should be at least nine days. Why was nine days chosen by the government? Is it because that was the time the ministerial expert panel chose? What consideration was given to having a longer period?

Hon STEPHEN DAWSON: The fact that nine days is used in Victoria was considered, and that was where we landed.

Hon NICK GOIRAN: Was that just slavishly following the Victorian model then, minister? Take that as rhetorical.

Hon Stephen Dawson: I have taken it that way.

Hon NICK GOIRAN: Section 241.2(3)(g) of the Canadian Criminal Code requires —

> … at least 10 clear days between the day on which the request was signed by … the person and the day on which the medical assistance in dying is provided or—if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent—any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

The latest government report from Quebec indicates that 40 per cent of medical assistance in dying cases were performed less than 10 days after the patient first made a request. Given that from the latest data the rate in Quebec

is 40 per cent, does the government anticipate that in Western Australia we will see similar levels of expedited final requests and an administration of voluntary assisted dying substances inside the designated nine-day period as outlined in clause 47?

Hon STEPHEN DAWSON: Obviously, the laws in Quebec do not necessarily mirror the bill before us. I will just say that it is impossible to foresee.

Hon NICK GOIRAN: Clause 47(3) provides that if, in the opinion of the coordinating practitioner for the patient, the patient is likely to lose decision-making capacity before the end of the nine days, the patient's final request can be made before the nine-day period has elapsed. In what circumstances might a coordinating practitioner be able to determine that a patient is likely to lose decision-making capacity before the end of nine days?

Hon STEPHEN DAWSON: An example of a situation that may satisfy the clause 47(3) provisions is when a person's loss of decision-making capacity may occur from high doses of pain medication.

Hon NICK GOIRAN: If a person is assessed as being on the verge of losing capacity, what degree of certainty can there be that the person currently has full capacity?

Hon STEPHEN DAWSON: A doctor assesses decision-making capacity to, I guess, the same level. If they know the likelihood of the pain medication that the patient would be required to take would result in them losing capacity, they could act.

Hon NICK GOIRAN: If a patient's request is expedited under clause 47(3), what is the minimum period in which the entire request and assessment process can take place?

Hon STEPHEN DAWSON: Technically, it is two days, and I think the honourable member knows that. I am advised that that is highly unlikely, given the steps that need to be followed—making a formal request, the assessment being undertaken by the coordinating practitioner, the assessment being undertaken by the consulting practitioner, the written declaration, the final request and the final review. Technically, it is two days, but we anticipate longer.

Hon NICK GOIRAN: If the patient's request is expedited under clause 47(3), we now know it can all happen within two days. I have to say that I am really troubled that we are going to put some Western Australians on this express pathway and that the whole process can happen within two days. Are we as legislators going to pretend that this board will somehow provide oversight for a process that can happen in two days? I just want members to reflect on that for a moment. I find that reckless. Two days—the express pathway for a Western Australian patient. I know that the government has boasted over the course of the journey of this bill that there are supposedly 100-odd safeguards. What could possibly go wrong in two days on this express pathway? Be that as it may, in the absence of anyone else sharing the concern that that will happen under clause 47, we will set Western Australians on this express two-day pathway.

If people do access this expedited route at clause 47(3), can the minister indicate to us how the patient's request can then be assessed as enduring, as required by eligibility clause 15(1)(f) and clause 58(5)(c)?

Hon STEPHEN DAWSON: I want to clarify that. It is technically possible, but that does not mean that it is operationally likely. I am told it is highly unlikely that the practical process will be two days. The endurance assessment is made at the first request. The coordinating practitioner will take all relevant health information on board to determine the matter of endurance.

Hon NICK GOIRAN: I had understood during an earlier part of the debate that the minister indicated that the patient would need to have decision-making capacity at the time of administration. If that is true, how can the final request be accelerated on the view of the practitioner that the person is likely to lose decision-making capacity within the nine-day period?

Hon STEPHEN DAWSON: I want to say two things. The patient may lose decision-making capacity, and this qualifies for the waiver; however, if they have lost decision-making capacity, they are not eligible. At the time of making the administration decision, the medical practitioner may advise that the self-administration method is not suitable.

Hon NICK GOIRAN: They may advise that, but they may also proceed under the practitioner administration method. We need to know: at what point does decision-making capacity become irrelevant? Once somebody has accessed the express pathway under clause 47, does decision-making capacity remain relevant any longer?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: The patient has accessed the express pathway under clause 47. The coordinating practitioner has allowed that to take place because the coordinating practitioner, in his or her opinion, says that the patient is likely to lose decision-making capacity. After that, the patient loses decision-making capacity. Is there not a process whereby the patient needs to make an administration decision? In any event, assume for a moment

that the person has elected for the practitioner administration process and then loses capacity, and this is all being done within the nine-day period because they have accessed the express pathway, to what extent is decision-making capacity still relevant in any of those processes?

Hon STEPHEN DAWSON: Clause 58(5)(a) deals with this issue. Its states —

> The administering practitioner for the patient is authorised, in the presence of a witness, to administer the prescribed substance to the patient if the administering practitioner is satisfied at the time of administration that —
>
> (a) the patient has decision-making capacity in relation to voluntary assisted dying …

Hon NICK GOIRAN: The patient has accessed the express pathway. It will now take place in less than nine days—possibly two days, as we have discussed. The patient has lost capacity. The practitioner knew that that was going to happen because they certified the express pathway because they were concerned that the person was going to lose capacity—as the minister said, potentially because of the painkilling medications that the person is taking. They lose capacity and that eliminates from them the possibility of practitioner administration. Is self-administration still an option at that stage?

Hon STEPHEN DAWSON: If they have lost capacity, they cannot self-administer. I also wanted to raise that the so-called express pathway does not change the requirements and eligibility for access to voluntary assisted dying and this includes decision-making capacity. These are elements for discussion at clause 57, "Self-administration".

Hon NICK GOIRAN: That may be convenient, minister, but at this point in time we have to decide whether we are going to agree to clause 47. I am trying to understand, in effect, that if a practitioner allows the express pathway because they are concerned that the person is likely to lose decision-making capacity, and then the patient loses capacity thereafter, have they eliminated as an option practitioner administration because of the clause that the minister referred to and are they left only with self-administration? The minister indicated that it is not possible for someone to self-administer if they lose decision-making capacity. I am not sure how that can be the case given that the person takes the substance home with them. We have already ascertained that there is no supervision over that whole process, so I do not think that the advice that the minister received on that point can be correct. We surely have to get to the bottom of this. If we are going to allow patients to complete the whole process in two days, what I hear from the minister is that if they lose capacity, the only option at that point will be self-administration. I am hearing from the minister that there is at least a safeguard; that is, if somebody accesses the express pathway and then loses capacity and has chosen practitioner administration, they are safe because the practitioner will not perform the final injection if the person has lost capacity. That is a good thing and I support that. But I remain concerned that the other pathway might effectively be steering them down self-administration, and I want an assurance from the minister that there is definitely no possibility of a patient accessing the express pathway and choosing self-administration and losing capacity.

Hon STEPHEN DAWSON: I just want to clarify—I think Hon Nick Goiran has indicated this—that if a patient has chosen practitioner administration and then loses capacity, they must go back to the coordinating practitioner for a new administration decision. But they would not be eligible if they have lost capacity. If a person has chosen the self-administration method, it is no different whether they are on the express pathway or the regular pathway, to use that terminology; they are prescribed a substance and they have self-autonomy to take it.

Hon NICK GOIRAN: Yes, I agree with that, minister. This is further and further convincing me that in due course—I think Hon Rick Mazza is seeking to remove self-administration from the scheme; correct me if I am wrong, honourable member.

Hon Rick Mazza: Not remove self-administration, but —

Hon NICK GOIRAN: That amendment will definitely have my support, because clause 47 has convinced me that if ever there were a case for it, this is it. How can we have a situation in which a doctor says, "We're going to accelerate this process for this patient because I'm concerned that in the next nine days, this patient is going to lose capacity"? Within that nine-day period, that practitioner also extracts an administration decision out of that patient, who still has capacity. The administration decision is that the person self-administers. Off they go with their substances, and after the nine days, in the full knowledge of the doctor who has determined that the person is going to lose capacity in nine days, the doctor says, "Off you go with your poison. Go and take it 10, 12, 15 or however many days later." That should be prohibited under this legislation. One way of doing it will be to ensure that there is somebody present. We will look at those amendments in due course, so long as they ensure that somebody says at the time of self-administration that the person has decision-making capacity, because if they do not, then absolutely there needs to be not just a pause button, but a stop button, hit.

Clause put and passed.

Clause 48: Coordinating practitioner to record final request —

Hon NICK GOIRAN: Why is this clause deemed necessary for inclusion and is there an equivalent in the Victorian legislation?

Hon STEPHEN DAWSON: My advisers tell me that it is not in the Victorian legislation. The purpose of this provision is to reflect the progression and enduring nature of the request and assessment process. It is an administrative record-keeping requirement and allows resources to be provided to assist the patient through the voluntary assisted dying process if they so require.

Clause put and passed.

Clause 49: Coordinating practitioner to notify Board of final request —

Hon NICK GOIRAN: I move —

Page 30, after line 31 — To insert —

(ea) if the patient was assisted by an interpreter when making the final request, the name, contact details and accreditation details of the interpreter;

Hon STEPHEN DAWSON: The government is supportive of this amendment. Similar amendments were moved earlier in the bill. Reasons were given at that stage, so I do not propose to give them again, other than to say we support it.

Amendment put and passed.

Hon NICK GOIRAN: What is the board required to do with the financial request form once it has been received from the coordinating practitioner?

Hon STEPHEN DAWSON: The intent of this provision is to ensure that the board is notified progressively of the patient's participation in the voluntary assisted dying process, including the outcome of each assessment to track that the correct process is being followed in each case of voluntary assisted dying and to maintain complete and accurate statistics of participation in voluntary assisted dying in Western Australia.

Hon NICK GOIRAN: What special measures will the board take in the event that it receives a final request form that indicates that a patient has taken advantage of the express pathway?

Hon STEPHEN DAWSON: None will be taken.

Hon NICK GOIRAN: No special action will be taken by the board when somebody has accessed the express pathway. It can all happen in two days. Normally, the legislation says nine days, but in certain circumstances it can happen within two days and the board will proceed at a normal pace. Maybe the board will have meetings once a week, but, of course, that will be too late in this instance. The board will receive the final review and say, "Thank you very much, coordinating practitioner. We will file away your final review form and look at it in seven days." Seven days later, the board will look at it and realise that there is a manifest error. It will be too late; the funeral will already have taken place. That situation is untenable. I realise that at the moment we are not in a position to deal with the resources for the board; however, this highlights once again that this board will have to be on red alert. Every time it receives a form, it will need to drop everything and make sure that the patient is not being taken advantage of and that ineligible people have not accessed it. If somebody is said to be losing their capacity within the next nine days, if that is the reason that is provided by the practitioner, absolutely everyone needs to be on red alert. I trust that those things will be taken into account by the government during the 18-month implementation phase.

Clause, as amended, put and passed.

Clause 50: Final review by coordinating practitioner on receiving final request —

Hon ADELE FARINA: What is the purpose of clause 50(1)(a)? The coordinating practitioner has to review the first assessment report form, all consulting assessment report forms and the written declaration. What is the purpose of that review?

Hon STEPHEN DAWSON: This clause sets out the requirements of the final review that the coordinating practitioner must undertake on receipt of a patient's final request for access to voluntary assisted dying. The purpose of the final review is for the coordinating practitioner to review all the forms completed throughout the request and assessment process, complete the final review form for the patient and certify whether the request and assessment process has been completed in accordance with the legislation. The final review will provide the coordinating practitioner with the opportunity to ensure that all the necessary steps in the request and assessment

process have been completed. The coordinating practitioner is not required to repeat those steps. They are required to ensure that every step has been properly adhered to.

Hon ADELE FARINA: As I understand it, the coordinating practitioner is required to provide the first assessment report, the consulting assessment report forms and the written declaration to the board. If there were a deficiency with those forms and those reports, would the board not contact the coordinating practitioner to advise that there were deficiencies in the forms that had been provided to the board and to immediately correct them?

Hon STEPHEN DAWSON: Yes; in practice I agree with Hon Adele Farina, but this is an assurance step, if I can call it that.

Hon ADELE FARINA: Will the person who is supposed to properly complete these forms be the person who will also be tasked with the job of ensuring they have been correctly completed?

Hon STEPHEN DAWSON: They are not the person who will complete all the forms. Clause 50(1)(a) refers to the first assessment report form, all consulting report forms and the written declaration. That would not necessarily be the person completing all the forms; it would be other people, too.

Hon CHARLES SMITH: Can the minister confirm that under clause 50(1)(a) the board will review all the paperwork for the final request?

Hon STEPHEN DAWSON: The board has a monitoring function rather than a clinical function. Clause 117, "Functions of Board", states —

> The Board has the following functions —
>
> (a) to monitor the operation of this Act;
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> …
>
> (c) to refer to any of the following persons or bodies any matter identified by the Board in relation to voluntary assisted dying that is relevant to the functions of the person or body —

I will let Hon Charles Smith read the rest. Clause 50(4) states —

> Within 2 business days after completing the final review form, the coordinating practitioner must give a copy of it to the Board.

Hon NICK GOIRAN: Is it not the case that we moved an amendment earlier at clause 39 that will ensure that when receiving the consulting assessment form, the board will also receive a copy of any report given by the registered health practitioner or other person to whom the patient was referred?

Hon STEPHEN DAWSON: Yes, that is the case.

Hon ADELE FARINA: I move —

> Page 31, after line 29 — To insert —
>
> (da) if the patient was assisted by an interpreter, the name, contact details and accreditation details of the interpreter;

I do not want to take credit for this. This is an amendment moved earlier by Hon Nick Goiran. I am simply seeking to ensure that it fits in where it is needed in subsequent clauses.

Hon STEPHEN DAWSON: The government supports this amendment.

Amendment put and passed.

Hon NICK GOIRAN: Clause 50(2) refers to decisions made by the tribunal. What type of decisions might be made by the tribunal under part 5 of the bill in respect of a decision made in the request and assessment process that the coordinating practitioner may be required to have regard to under clause 50(2)?

Hon STEPHEN DAWSON: Clause 87 identifies the types of decisions that can be taken into account or whatever the language the honourable member used.

Hon NICK GOIRAN: Schedule 1 of the Victorian legislation provides the forms that are required to be completed under the request and assessment process of its act. The information required to be included in the final review form is included in clause 50(3), but the form itself is not found in the schedule to the bill. Why has the final review form not been included in the schedule to the bill?

Hon STEPHEN DAWSON: I am advised that the forms will be developed during the implementation phase.

Hon NICK GOIRAN: Clause 50(3) requires only that the coordinating practitioner's name and contact details be included in the final review form. Why is information about the coordinating practitioner's experience and training in the patient's disease, illness or medical condition missing from inclusion in the final review form? The context, of course, is that we know that in certain circumstances, the practitioner may not necessarily have the right experience and training. There is a discretionary provision in the bill indicating that they should refer elsewhere. That is the kind of information I would like the board to have so that it can perform its oversight function.

Hon STEPHEN DAWSON: There is no requirement for them to be a specialist in the disease, as the honourable member said.

Hon Nick Goiran: I didn't say "specialist".

Hon STEPHEN DAWSON: I thought you did. What word did you use?

Hon Nick Goiran: I said they do not have any experience or training in the patient's disease.

Hon STEPHEN DAWSON: Sorry; to use the member's language, there is no requirement for them to have that. Clause 16 outlines the eligibility criteria of the coordinating practitioner.

Clause, as amended, put and passed.

The DEPUTY CHAIR: I draw members' attention to supplementary notice paper 139, issue 15, page 3 and the proposed amendment by Hon Charles Smith in relation to a new part.

Hon STEPHEN DAWSON: It is my understanding that the amendment standing at 37/ND7 would be moved as a consequence of the amendment of proposed new clause 52A. If that is the case, the honourable member may wish to park the first one and we may go back to it subsequently, depending on the success or not of proposed new clause 52A.

The DEPUTY CHAIR: Sorry, minister, I was distracted through that. Is Hon Charles Smith going to move his amendment?

Hon CHARLES SMITH: Yes, thank you, Madam Deputy Chair. I think we need to seek to defer the new clause.

Point of Order

Hon COLIN HOLT: I might have missed it, but have we passed clauses 51 and 52?

The DEPUTY CHAIR (Hon Adele Farina): This comes in before then. If you read the proposal, it is at page 32, after line 13.

Committee Resumed

The DEPUTY CHAIR: Hon Charles Smith, you are seeking just to defer that amendment until later?

Hon CHARLES SMITH: That is correct, Madam Deputy Chair.

The DEPUTY CHAIR: Okay, we will not deal with that at this time. The question now is that clause 51 stand as printed.

Clause 51: Technical error not to invalidate request and assessment process —

Hon NICK GOIRAN: What might constitute a "minor or technical error in a final review form" that would not affect the validity of a voluntary assisted dying request and assessment process for the purposes of clause 51?

Hon STEPHEN DAWSON: Examples of a minor or technical error include a spelling error in a name or address, or an accidentally incorrect date on a witness's signature. Such things should not have the effect of invalidating a patient's entire request and assessment process.

Hon NICK GOIRAN: What type of error contained in a final review form might affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: Anything other than a minor or technical error will mean that the form is invalid. For example, anything that in substance affects the operation, integrity or meaning of the form will render the form invalid. Examples of matters that would have a substantive invalidating effect include situations in which the form is unclear about whether the core requirements of an assessment have taken place—that is, that the patient meets each of the eligibility criteria and reasons—or in which the names of the assessing practitioners cannot be ascertained. I am advised that other Western Australian legislation has this type of clause.

Hon NICK GOIRAN: That might be true, but there is no other piece of legislation —

Hon Stephen Dawson: Just being helpful, honourable member.

Hon NICK GOIRAN: I know the minister is, but I am also just making my assessment in respect of that remark. I think this is the only piece of legislation that authorises one Western Australian to take the life of another, albeit with the supposed consent of that individual, so I think this is a unique piece of legislation. Be that as it may, are there any errors other than those contained in the final review form that might affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: I am sorry; would the honourable member ask his question again, please?

Hon NICK GOIRAN: Are there any errors other than those contained in the final review form that may affect the validity of a voluntary assisted dying request and assessment process?

Hon STEPHEN DAWSON: I refer the member to clause 50(1)(a). Those are the forms that clause 51 refers to.

Hon NICK GOIRAN: Clause 50(1)(a) lists things that a practitioner needs to review prior to completing the final review form, but my question was: are there any other errors that can take place, other than those contained in the final review form, that may affect the validity of a voluntary assisted dying request and assessment process? Clause 51 provides that if there are any minor or technical errors in the final review form, they will not affect the validity of the request and assessment process. Subsequent to that, the minister indicated some types of errors in a final review form that might affect the validity of the process. My question is: is there something outside that? Are there some other errors that could be made that would affect the validity of the process, or is it all only contingent on the accuracy of the final review form? I would assume that there must be some other errors that can be made, other than merely in the final review form. I am trying to ascertain what those other errors are.

Hon STEPHEN DAWSON: If the member is talking about errors in general, a failure to make an assessment of a patient's capacity would be an example of an error in the assessment process.

Hon NICK GOIRAN: What remedy would there be for a patient if an error is made by one of the practitioners in the assessment process that affects the validity of the patient's request and, thereby, their access to voluntary assisted dying is prevented or delayed by the error?

Hon STEPHEN DAWSON: There would be the option of civil action.

Hon NICK GOIRAN: When the minister says civil action, would it be some form of negligence claim against the practitioner to claim that the patient has suffered some form of pain, suffering, loss of enjoyment of life and the like as a result of their delayed access to voluntary assisted dying; is that the type of thing the minister is referring to?

Hon STEPHEN DAWSON: Yes. That is theoretically possible.

Hon NICK GOIRAN: Would that remedy be available to the patient's family in the event that the patient deceases before the civil action has taken place?

Hon STEPHEN DAWSON: The answer is no. The remedy would not be available to the family if the person has deceased.

Hon NICK GOIRAN: There will be no remedy available to the patient's family. The only remedy would be available to the patient and it is available only to the patient for as long as they are alive.

Hon STEPHEN DAWSON: That is correct.

Clause put and passed.

Clause 52: No obligation for patient to continue after completion of request and assessment process —

Hon NICK GOIRAN: Is there any point after the coordinating practitioner has completed the final review forms and the request and assessment process is deemed complete at which the voluntary and enduring nature of the patient's request is further assessed?

Hon STEPHEN DAWSON: The test of the endurance will be demonstrated by attending the appointment with the medical practitioner to make the administration decision—that is clause 55—and then when the substance is prescribed for them. In the case of practitioner administration, enduring capacity will be assessed before administration. During the course of the appointment for the administration decision, if the medical practitioner is not satisfied of any of these, they will not be compelled to proceed.

Hon NICK GOIRAN: Clause 52 states that there will be no obligation on the part of the patient to continue the process after the request and assessment process is completed. That is quite appropriate. I do not think it is even necessary for us to state that in the statute; it would already be right for a patient in any event, whether we had clause 52 or not. I am not so sure that clause 52 adds anything, but I certainly do not object to its inclusion. Would it not be better to ensure as a safeguard that a practitioner cannot follow up a patient in the circumstances? If the

patient does not want to continue to exercise their right under clause 52, they should be left in peace. Is there any prohibition against a practitioner continuing to initiate conversations with a patient at this point?

Hon STEPHEN DAWSON: I am told it is contrary to good medical practice. I remind the honourable member that during the implementation phrase of this legislation, training will be undertaken with the various practitioners who will be involved in implementing the bill.

Hon NICK GOIRAN: For what it is worth, there should be a penalty against a medical practitioner who pursues a patient after they have exercised their right under clause 52. If they say they do not want to continue anymore, they should be left in peace, they should be left alone and they should not be pursued by an aggressive medical practitioner. If they were, albeit we would hope those circumstances would be rare, there should be a significant penalty and the penalty should be more than some form of professional misconduct against the practitioner. Some criminal penalty should be applicable, given, as we identified earlier, that under this bill, if practitioners fail to submit forms to the board, they can be up for a penalty of up to $10 000. I would like to think a penalty far greater than that would apply to a medical practitioner who pursues a patient after they have exercised their clause 52 rights.

Hon STEPHEN DAWSON: Australian Health Practitioner Regulation Agency sanctions may apply, but the member's comments are noted.

Clause put and passed.

New clause 52A —

Hon CHARLES SMITH: I move the new clause standing in my name.

The DEPUTY CHAIR: Hon Charles Smith has moved the new clause standing in his name. It is new clause 52A at 38/NC52A on the supplementary notice paper and it seeks to insert at page 32, after line 23, a fair bit of script. I assume that everyone has the supplementary notice paper and I will not take the time of the chamber to read it, so I give the call to Hon Charles Smith.

Point of Order

Hon NICK GOIRAN: I have a point of order, Madam Deputy Chair.

The DEPUTY CHAIR (Hon Adele Farina): Are you going to make me read it?

Hon NICK GOIRAN: Not necessarily. I am happy for it not to be read, but I want to know, will it appear in *Hansard* for those people who are following the debate?

Committee Resumed

The DEPUTY CHAIR: That is absolutely a fair point, because people are following the debate online. I will read it. Hon Charles Smith has moved —

Page 32, after line 23 — To insert —

52A. Board to be notified if patient decides not to continue or if request for access to voluntary assisted dying ceases to be enduring

(1) This section applies if —

(a) at any time before the request and assessment process in respect of a patient is completed, the patient informs the coordinating practitioner for the patient of a decision not to continue the request and assessment process; or

(b) at any time after the request and assessment process in respect of a patient has been completed, the patient informs the coordinating practitioner for the patient of a decision not to take any further step in relation to access to voluntary assisted dying; or

(c) at any time after making a first request, a patient's request for access to voluntary assisted dying ceases to be enduring because the patient indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

(2) The coordinating practitioner or administering practitioner referred to in subsection (1)(a), (b) or (c) must —

(a) record the decision, or that the request has ceased to be enduring, in the patient's medical record; and

(b) within 2 business days after being informed of the decision, or after the request has ceased to be enduring, complete the approved form (the ***request cessation form***) and give a copy of it to the Board.

(3) The request cessation form must include the following —

(a) the name, date of birth and contact details of the patient;

(b) the name and contact details of the person completing the form;

(c) if the person completing the form is not the coordinating practitioner for the patient, the name and contact details of the coordinating practitioner;

(d) the date when the first request was made;

(e) if the request and assessment process in respect of the patient has been completed, the date when the final review form was signed;

(f) the date when the coordinating practitioner was informed of the decision referred to in subsection (1)(a) or (b), or the date when the request for access to voluntary assisted dying ceased to be enduring as referred to in subsection (1)(c), as the case requires;

(g) the signature of the person completing the form and the date when the form was signed.

Hon CHARLES SMITH: I appreciate that and I am sure the chamber does as well.

I first draw members' attention to clause 52 itself, which states —

> A patient in respect of whom the request and assessment process has been completed may decide at any time not to take any further step in relation to access to voluntary assisted dying.

Members will also note that as the bill currently stands, there is no requirement for any note to be made on a patient's record, or any notification to the VAD board, to document the cessation or the patient's request to stop. This new clause, which is lacking in our WA model, is taken from the Northern Territory model. It is inspired by section 10(2), which requires —

> Where a patient rescinds a request, the patient's medical practitioner shall, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record.

Quite simply, new clause 52A will require the coordinating practitioner to notify the board of a patient's decision not to continue with the application to access voluntary assisted dying, whether this occurs during the request and assessment process or after the request and assessment process is completed; therefore, a new form, the "request cessation form", will be required to be completed and submitted to the Voluntary Assisted Dying Board. This only further strengthens the oversight functions of the board and in this particular case, in this important part of the journey, that is wise to be documented.

Hon STEPHEN DAWSON: Hon Charles Smith's new clause seeks to formalise when a patient decides not to continue with the request and assessment process. We are not supportive of the amendment. My advisers tell me that the inclusion of the amendment adds to the complexity and bureaucratic burden of the bill. The coordinating practitioner would be able to make a note on the person's medical file and to record, via the recording system, if the patient makes a formal decision to withdraw from the voluntary assisted dying process. We do not believe that what Hon Charles Smith is asking us to do is needed.

Hon NICK GOIRAN: I am not convinced by that, because when we discussed clause 52, I indicated that I think there should be a prohibition against a doctor pursuing a patient who does not want to proceed down this path. We do not have that in the bill and this new clause does not do that either, but at the very least this new clause seems to make sure that the board is aware of what is going on. I would have thought that that was a good thing. The minister indicated that this would be too bureaucratic. Correct me if I am wrong, but it appears that, under this new clause, the only person who will have to do anything is the practitioner, and they will have two business days to let the board know that they have been told the patient does not want to continue. I think that is a good thing. That way, if the board hears anything further about this particular patient, that is going to be a red flag for them, because they will have known from this other practitioner that the patient has already said they do not want to pursue it. If a new practitioner suddenly appears on the scene and forms are flying into the board, at least there is a red flag. I think this is a good safety mechanism; I just do not think it goes far enough. I would like to see this, plus a prohibition and a penalty against a practitioner who decides to pursue a patient, but we do not have that type of amendment before us. In the absence of that, it is not clear to me what is so bureaucratic about a coordinating practitioner having to send in a request cessation form, as I see it, within two business days.

Hon STEPHEN DAWSON: I said that it adds to the complexity and bureaucratic burden rather than that it was "too bureaucratic" or whatever words Hon Nick Goiran used. During the debate we have clarified and made changes to the bill that will give extra responsibilities or, indeed, jobs to the board. This proposed new clause seeks to create another form and more work for the board—or more information that needs to be provided to the board. As I have said previously, the coordinating practitioner would be able to make a note on the person's medical file and they could record it via the reporting system if the patient makes a formal decision to withdraw from the voluntary assisted dying process. I know that Hon Nick Goiran said that this does not go far enough for him and there are other changes he wants to make. For us, we do not believe it is needed; we believe the system as outlined in the bill before us on this issue does not need to be changed.

While I am on my feet, I might take the opportunity to ask Hon Charles Smith whether this new clause came wholly from the Northern Territory legislation. I am not being disparaging. Was this a cut and paste? Did the member copy clauses from the Northern Territory legislation and bring them across?

Hon Charles Smith: That's correct.

Hon AARON STONEHOUSE: I have a question for the mover of the proposed new clause. Are there any consequential amendments that come along with this? Are there any other references to the request cessation form in any consequential amendments?

Hon Charles Smith: I don't believe there are.

Hon AARON STONEHOUSE: I am looking at how this proposed new clause would work. If we jump ahead a bit in the bill, we see clause 56, "Revocation of administration decision", which states —

> (1) The patient may at any time —
>
> > (a) revoke a self-administration decision by informing the coordinating practitioner for the patient that the patient has decided not to self-administer a voluntary assisted dying substance …

In which case a medical practitioner or the coordinating practitioner must, under subclause (3) —

> > (c) within 2 business days after the revocation, complete the approved form (the ***revocation form***) …

This provision is rather similar, but I think the proposed new clause fits in a little earlier in the process. Proposed new clause 52A states —

> (1) This section applies if —
>
> > (a) at any time before the request and assessment process in respect of a patient is completed, the patient informs the coordinating practitioner for the patient of a decision not to continue the request and assessment process;

Although there is already a reporting mechanism for a patient cancelling just prior to self-administration, this would create a reporting obligation for the medical practitioner earlier in the process, presumably before the patient has been provided with the voluntary assisted dying substance. It can be at any time before the request and assessment process for the patient is completed. I suppose it does add to the administrative burden of coordinating practitioners, but I do not think it is inappropriate necessarily, in that there is already the revocation form that would have to be completed at that stage. This is merely replicating a reporting mechanism that exists at the end of the process and is putting it a little earlier in case a patient wants to opt out at that stage. I think the policy intent is solid and desirable. There will be more reporting to the board and more opportunities for the board to provide oversight of this process. Given that the board does not have a gatekeeping or approval role, but merely an oversight role, it will provide the board with more information. It might be helpful as well in later years for looking back and reviewing the voluntary assisted dying regime to find out how many people go through the process and then opt out. I am interested to know whether it would be possible to record why somebody decided not to continue. Did they decide not to continue because they found that their palliative care treatment options would be sufficient in their case or was there some other consideration? Obviously, we all want to respect patients' privacy, but that kind of information might be helpful. I am not suggesting that it be amended to include that, but it is something worth bearing in mind.

Although I appreciate that the proposed new clause would create an additional administrative burden, I am inclined to support it because it does add to transparency and potentially creates a safeguard if the board does its job properly. It seeks to strengthen the protections in this bill.

Hon MARTIN ALDRIDGE: I am seriously considering the proposed new clause before us. I understand the operation of the proposal but I do not necessarily understand the mischief or perceived mischief that the member is trying to address. I take Hon Aaron Stonehouse's point about gathering more information that may be useful

down the track, but we have to balance that with the added layers and requirements we would place, in this case, on practitioners. We have to balance those competing concerns. Looking at the bill, and not having a chance to collate all the reporting provisions, I see that there are many reporting provisions to the board in the bill, but they usually relate to—in fact, they may entirely relate to—the progress of a patient through the process, whereas this is a situation in which a patient ceases to participate in the process. If this proposed new clause is being framed as a safeguard—I am not sure that it is—what is it a safeguard from? Along a similar line to what Hon Aaron Stonehouse said, what is the value in passing this new clause that I need to balance in deciding whether to add this burden on a practitioner?

Hon JACQUI BOYDELL: At the moment, I am probably inclined to not support the proposed new clause for a couple of reasons. I heard other members talk about transparency and the value of recording the reasons someone might revoke their request, but by imposing this new clause, information would be captured only when a patient makes a record of their request to not participate. I would envisage in the operation of voluntary assisted dying that there would be people who are eligible, access the scheme and decide for self or physician administration and then ultimately do not follow through and take the substance so they die without accessing voluntary assisted dying. We will never record that because the patient has made the decision themselves, which brings us back to the point that this legislation is voluntary and it is about the patient and the patient making decisions. We should not force that patient to have to then formally report that they did not take the substance because that is their decision. We will not get any stats that truly reflect whether someone has changed their mind because we will only capture the people who make a formal request. A whole lot of other people will not access voluntary assisted dying and will not take the substance, although they might have it in their possession, and pass away peacefully with their family around them. They do not need to take the substance, so we will never capture them. Therefore, I will not be supporting the proposed new clause.

Hon STEPHEN DAWSON: It is my belief that Hon Charles Smith's proposed new clause could put unnecessary pressure on the patient. The process is patient centred and the framework is based on a principle that the patient moves it forward, that they are in control and that they decide when to go to the next stage. Requiring formal cessation could have the unintended consequence of placing the patient in the position of having to move forward at a time when they wish to pause, so I also agree with what Hon Jacqui Boydell has just outlined.

Hon AARON STONEHOUSE: Just to provide some further clarity, if a patient is given the voluntary assisted dying substance and they then decide to cancel or put an end to the process, there is a reporting requirement in that instance—that already exists. That is the revocation form, which the coordinating practitioner must complete. This would create an additional reporting obligation earlier in the process. I take the point. In a lot of cases, we would not know, but I imagine that a lot of people would begin the process, begin the discussion, and then simply not follow through the cycle. Sadly, people may pass away before they have an opportunity to go through the entire process. However, this proposed new clause would not put any obligation on the patient. This is an obligation on only the medical practitioner if the patient makes a cessation request to the practitioner. I understand the concern that pressure might be brought to bear on a patient, but nothing in this amendment would do that. I think that would happen only if the medical practitioner was overstepping their bounds and unnecessarily or inappropriately putting pressure on their patient. That is something that there is already a risk of anyway, so I do not think that this amendment would add any new risk of pressure being brought to bear on patients.

An aspect of this amendment that has been overlooked so far is new subclause (1)(c), which states —

> at any time after making a first request, a patient's request for access to voluntary assisted dying ceases to be enduring because the patient indicates to the coordinating practitioner or administering practitioner for the patient that the patient does not wish to continue the request and assessment process or access voluntary assisted dying.

That is slightly different from a patient merely changing their mind at an earlier stage. It provides for before the request and assessment process, after the request and assessment process and after making a first request. It provides a reporting mechanism all the way through until the end. Currently, we have a reporting mechanism for opting out only at the very end. Although it may again be an additional administrative burden, in situations in which a patient makes an overt request to their medical practitioner to cease the process, I think it would be helpful to have that recorded.

We are not asking for a lot of information in this instance; it is the same information that would be included in a lot of the other forms that a medical practitioner will be required to fill out. It is very similar to the information in the final request form, in the final review form and in the first request form. It is the name, date of birth and contact details; if the person filling in the form is not the coordinating practitioner for the patient, the name of the coordinating practitioner; and the date that the first request is made. This information would already be at hand.

Again, although it does add to the administrative burden, I do not think it does so unnecessarily. The medical practitioner already has to fill out quite a number of forms as part of this process, and it would apply to only a very small section of patients who begin the voluntary assisted dying process and make that overt request to their medical practitioner to cease the process before they get to the administration phase. Again, I do not see a problem with this proposed new clause, and I am inclined to support it at this time.

Hon COLIN HOLT: I have a quick question for the mover of the motion. I wonder whether he could explain the interaction of this new proposed clause with clause 21, which states that, on the first request, the medical practitioner must complete the approved form—the first request form. How will that clause interact with proposed new clause 52A?

Hon CHARLES SMITH: It will work in harmony with that clause as a total record-keeping process. The idea is that records will be kept the whole way through the voluntary assisted dying journey so that in years to come we can study how well VAD is working. That is the idea.

Hon JACQUI BOYDELL: I will put a scenario to the chamber. There may be five patients who go through the process of accessing voluntary assisted dying. They follow the procedure all the way through. One of those five patients might overtly—to use the words of Hon Aaron Stonehouse—go to their coordinating practitioner and say that they do not want to participate anymore. Two of the remaining four patients may pass away without accessing the substance, which is returned, and the remaining two patients may actually follow through and take the substance. The reporting requirements as suggested in the proposed new clause will not capture any statistical information for the board to reflect on, moving forward—either the decisions made by the patient or the reasons for taking or not taking the substance.

In fact, information and historical data from overseas suggests that a lot of people who access voluntary assisted dying and receive the substance actually do not take it. Again, I say that we will only be recording the statistics of the people who put their hand up to fill out the form. I am still not clear what use that is for voluntary assisted dying, moving forward. I think it could also potentially cause some pressure for practitioners, when the board may come back to them and say, "Why didn't you keep asking the patient whether they were still enduring on their decision? Are you sure that they didn't want to withdraw?" I think there is a potential problem for practitioners, and I do not see any use of the collection of this data into the future, so I will not be supporting the motion.

Hon COLIN HOLT: I just want to pick that up. This proposed new clause adds to clause 21, under which the practitioner has to put in the first request form when the person makes the first request. If we take the numbers used by Hon Jacqui Boydell, if five people go in and make a first request, they may never go back and make another one, and they may never say to anybody that they are stopping the process, which seems to be the requirement in the proposed amendment. As soon as a patient ceases the process, someone is responsible for notifying the board of that cessation. However, a patient may go to step one and say, "I've gone to see my doctor", and they make a request that is unambiguous—I think they are the words used. They get some information about it, but they never proceed and never go back and say that they have changed their mind and they have stopped. A patient may well ask for information because they are curious about it, or whatever it might be, and they may never go back to even say that they are not proceeding after their first request. I am not sure how we deal with this. If we have this enacted in legislation, how will it interact with completion? Is there a time limit? If someone pushes pause for a little while, is that cessation? Is it only when they say, "I'm not going to go on with it"? Can the honourable member explain how it would work?

Hon CHARLES SMITH: What I have been trying to do throughout this debate is assist the state authorities and the government to keep more records of who is accessing voluntary assisted dying, why they are accessing it and when it stops. All that data can be collected for future analysis. This is just part of the process of who is accessing it, who is stopping it and at what stage they are stopping it, so for future reviews, whenever they may occur, we can see what is actually happening as best as we can. I understand that this is a greater bureaucratic burden, as members have said, but for us to have an accurate picture of how the legislation is working, it will be essential to collect as much data as possible.

Hon STEPHEN DAWSON: Hon Charles Smith just used the word "accurate", and I will go back to Hon Jacqui Boydell's point. There is no obligation on the patient to inform the practitioner, so the data of who elected not to proceed will not be complete. Therefore, the member's proposed new clause does not guarantee accuracy. That is another reason why we are not going to support it.

Hon AARON STONEHOUSE: I will make one very quick point about data. Hon Jacqui Boydell raised the point that the quality of the data recorded may not really warrant the recording of it in the first place, and that is true if we are looking for some kind of statistical narrative in aggregate data. However, it would be valuable in the sense of tracking individuals through the process, and that is something that we often overlook. When we look at aggregate

data statistically to try to get a snapshot of a situation, we often neglect what is happening to the individuals on the ground as they journey through this process. It may be valuable in that sense. I take Hon Jacqui Boydell's point that it is going to be valuable only to an extent, but I do not think it is —

Hon Jacqui Boydell: Only for the people who do it.

Hon AARON STONEHOUSE: That is right; it is only for those people who do it, so we should be realistic about the value of this data, but it is not completely relevant. I think it may be helpful in some regard.

Hon Jacqui Boydell interjected.

Hon AARON STONEHOUSE: We do not, obviously, but at the very least we would get an idea of those people who began the process and decided to opt out. That may provide information on the reasons why they opt out and how many people out of the total number of people who made an initial request did opt out. That would tell us something about —

Hon Jacqui Boydell: But you won't know that, because you don't know that someone made a personal choice.

Hon AARON STONEHOUSE: We would at least know the number of people who make a first request and of them we would know how many made a cessation request and how many followed through to make the final request and the administration request. Under the bill, we have a form for people who cancel at the administration phase. Obviously, that does not record those people who do not cancel at the administration phase and decide never to go to collect their prescription. There is obviously a gap in data there, too, so I take the member's point. We are getting only part of the picture, so it does call into question the quality of the data in an aggregate sense, but it can be useful. There is some value to that, but maybe much less than what was discussed earlier in this debate. I just wanted to point that out.

Hon NICK GOIRAN: There has been an interesting debate taking place in regard to data and I respect members who want to either support or oppose this amendment for data collection purposes. Can I just indicate that I am totally disinterested in data collection. My only interest is in patient safety. I am supporting this new clause because I believe this will be a yellow alert or a red flag—whatever language members want to use—to the board to say that a Western Australian patient has gone through all of this part of the VAD process and they have just spoken to their practitioner and said, "I don't want to do this anymore." I think it is good that the board will know that. I think it is good that the board will be told that the patient does not want to do this anymore, and what the board wants to do with that information is entirely up to it. I think it is actually one of the most helpful things that the board could receive. It will get a plethora of other forms, and I am not sure of the value of some of those forms in this process. But for it to be told that a Western Australian has accessed the system, qualified for certain aspects of it and has said, "No, I don't want this anymore", I think is a good thing. It provides clarity for the practitioner. I take the points about data collection, but, as I say, I am not motivated by data collection; I am motivated by patient safety.

Division

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

Ayes (5)

Hon Adele Farina	Hon Rick Mazza	Hon Charles Smith *(Teller)*
Hon Nick Goiran	Hon Aaron Stonehouse	

Noes (29)

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

New clause thus negatived.

Clause 53: Eligibility to act as administering practitioner —

Hon NICK GOIRAN: Clause 53(1)(a)(ii) allows for the administration of schedule 4 and schedule 8 poisons to cause the death of a patient to be performed by a nurse practitioner. Are nurse practitioners permitted to act as administering practitioners under the Victorian regime?

Hon STEPHEN DAWSON: No, they are not.

Hon NICK GOIRAN: Of the few jurisdictions around the world that allow these types of regimes, do any of them allow nurse practitioners to act as administering practitioners?

Hon STEPHEN DAWSON: I am advised that Canada does.

Hon NICK GOIRAN: The nurse practitioner who acts as an administering practitioner is required under clause 58(5) to be satisfied that the patient has decision-making capacity, is acting voluntarily and without coercion, and that the patient's request is enduring. Are these assessments under clause 58(5) assessments that a nurse practitioner would regularly undertake in the course of their usual nursing practice?

The CHAIR: Minister, if you want to entertain this question now and deal with it, you can; otherwise, I would have thought it should be reserved for consideration under clause 58, but I will let it go for the moment.

Hon STEPHEN DAWSON: Thank you. I will provide an answer now, and if there are further questions that warrant deferral to clause 58, we can do that. A nurse practitioner is a person registered under the Health Practitioner Regulation National Law (WA) Act in the nurse profession whose registration under that law is endorsed as a nurse practitioner. In order to be so endorsed, the person must first be a registered nurse, educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. They must also have completed an approved postgraduate master's degree. In Australia, the registered nurse must have 5 000 hours of advanced clinical experience before they are eligible to be endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia. On top of this, the bill requires that to be eligible as an administering practitioner, a nurse practitioner must have practised for at least two years post-registration as a nurse practitioner and must meet the requirements approved by the CEO. These requirements will include that the nurse practitioner has recent clinical experience that is complementary to understanding the requirements of the VAD process—so, not a management or leadership-type role. Currently, there are 248 nurse practitioners in Western Australia, 43 of whom are practising in WA country regions. It is important to have them potentially involved in the voluntary assisted dying process. They may undertake these assessments, as per Hon Nick Goiran's question, but they will have completed the mandatory training.

Hon NICK GOIRAN: By way of context for my line of questioning, at this stage I am inclined to seek to remove nurse practitioners as administering practitioners. That would involve the deletion of lines 11 to 15. However, before I move that, I want to be satisfied that there is a role that the nurse practitioner has to play and that they are well equipped to play it before I look to delete that provision, which will then have consequential effects on other clauses such as clause 58. We need to understand what exactly the nurse practitioner will be able to do. If the nurse practitioner is the administering practitioner, will they be capable of responding to any possible adverse reactions to the schedule 4 or schedule 8 poisons?

Hon STEPHEN DAWSON: Nurse practitioners are appropriately trained to prescribe and administer medication and to respond to any adverse event. They will have to undergo appropriate training as per the mandatory training requirements in the bill. During the implementation period, the Australian College of Nurse Practitioners and the Royal Australian College of General Practitioners will be consulted about the training modules. In relation to general practitioners, the college has offered to oversight and accredit the course to ensure that it contributes to overall professional standing. Nurse practitioners are fundamental to the operationalisation of the bill, particularly due to the geographic spread of the population in Western Australia.

Hon NICK GOIRAN: We know that that is not true because in an earlier part of the debate, the minister indicated that his government would guarantee flying up to eight people to any Western Australian who needed it. I specifically asked the minister about the administering practitioner. At no stage did the minister caveat that by saying that it depended on whether the person was a nurse practitioner and whether the nurse practitioner was available. None of that came up at all. The minister said that the government was fully committed to flying the administering practitioner and the interpreter if need be to any Western Australian. I recall giving an example of Kununurra and Hon Robin Scott and I had a discussion about my lack of knowledge about the other remote areas in Western Australia, about which he is far more equipped to speak. The point is this: it cannot be the case that we need to have nurse practitioners when the minister has said that he will fly out the administering practitioners anyway.

The other point I will make before I move my amendment is that it really troubles me that at the very final stage, the patient must demonstrate decision-making capacity and now we are going to subcontract this out to nurse practitioners. This is in the context in which the government's special adviser, Mr McCusker, on 14 November this year wrote to the Chief Psychiatrist. The Chief Psychiatrist said this in response —

> Psychiatrists and geriatricians are by far best placed to assess capacity, but other doctors who are trained and have ongoing appropriate credentialing may be appropriate—with the option to refer to a relevant psychiatrist in complex or challenging cases.

There is no mention whatsoever about nurse practitioners—not by the special adviser and not in any other document that has been presented to us. If the final act is the injecting of a patient with a lethal substance, that person has to demonstrate decision-making capacity. We had a discussion earlier today about an express pathway that some patients can take if the practitioner says that they might be losing capacity within a nine-day period. There is a possibility that the person might lose capacity during the nine-day period. We could put them on the express pathway and the final person who will provide the lethal injection is a nurse practitioner who does not even qualify under the Chief Psychiatrist's additional categories of individuals, as ascertained by this helpful email from the special adviser. For those reasons, I move —

> Page 33, lines 11 to 15 — To delete the lines.

The CHAIR: We will wait to receive a copy of the proposed amendment in writing. However, if any member wishes to make their remarks in response now, they can do so.

Hon RICK MAZZA: In considering this amendment and this clause, I would like a bit more information around the eligibility of the administering practitioner and how the government determined who would be eligible and who would not. Clause 53(1)(a)(i) refers to a medical practitioner who is eligible under clause 16(2), which refers to a medical practitioner being eligible to act as a coordinating practitioner. It refers to a specialist who has at least one year of medical profession experience. Clause 16(2)(b) refers to a general registration holder who has 10 years' experience. It seems to me to be somewhat disproportionate that a GP needs 10 years' medical experience and a nurse practitioner needs only two. Can the minister explain the rationale for the difference between those two professions and why one needs 10 years' medical experience and the other needs only two?

The CHAIR: Members, I think the amendment has been circulated in written form. Hon Nick Goiran has moved —

> Page 33, lines 11 to 15 — To delete the lines.

I indicate that on line 10, the word "or" will also be deleted as a clerk's amendment, but that need not concern us here.

Hon ALANNAH MacTIERNAN: I have not spoken very often, but I want to say that I feel really strongly about this provision, particularly as someone who has special responsibility in regional Western Australia. In Western Australia, we have seen the position of nurse practitioner thrive and prosper. There are far more nurse practitioners in Western Australia than in any other state of Australia and they form an absolutely critical role throughout regional Western Australia. It was a very, very sound choice to encode within this legislation the role of nurse practitioner being able to administer this medical assistance in these remote communities. There are very formal processes that will require two doctors but, at the end of the day, in many of these remote communities, the nurse practitioner has a very personal role with those communities. As I say, the whole development of that class of highly experienced nurses who are able to step up to the next level has proved to be a great success across Western Australia, including in Perth. It is a very important provision within this legislation that says that Western Australia is very different from Victoria. It is a much bigger state. We have a very considerable cohort of nurse practitioners, who have developed a great deal of acceptance in our community. I think it is perfectly appropriate that we allow them this role as administrators of this medical assistance.

Hon ALISON XAMON: I rise to indicate that I will not be supporting this amendment. I want to echo a lot of the comments of Hon Alannah MacTiernan. In addition, I would like to say that this amendment underestimates the degree of expertise our nurse practitioners bring to the medical profession these days. This is a profession that is highly professional. It is also a profession consisting of people who are often, in some ways, better qualified even than doctors to perform a lot of the tasks they do. I have had the privilege of working with nurses in a number of capacities over a number of years. I am aware that very often, the senior nurses have a far greater level of expertise than even a lot of junior doctors. I think it is really important to keep this provision to facilitate services appropriately to the regions. It is also important because it is recognition of just how senior these medical practitioners are.

Hon STEPHEN DAWSON: I agree with Hon Alison Xamon. Hon Nick Goiran is mischaracterising the abilities and skills of nurse practitioners. It is well within their skill set to carry out the administering role. A nurse practitioner has to have at least two years post-registration, but prior to that, to even become a nurse practitioner, a registered nurse must have 5 000 hours of advanced clinical experience. The issue was canvassed by the Ministerial Expert Panel on Voluntary Assisted Dying. At page 59 of its final report, it states —

> The Panel examined existing examples of collaborative models of medical practitioners working with nurse practitioners, including examples in aged care and end of life settings. In Canada, this extends to

> inclusion in medical assistance in dying … where nurse practitioners can be involved in all aspects of the process (including administration of intravenous medication for the purposes of voluntary assisted dying) and accounts for 6–7% of all cases.
>
> The Panel's view was that nurse practitioners' extensive training and scope of practice would enable them to function effectively in this role and would add to the provision of appropriate access to voluntary assisted dying across Western Australia.

A similar view was explored in the submission by the Western Australian branch of the Australian Medical Association, which states in part —

> The AMA (WA) contends that doctors do not necessarily need to be involved in the administration of lethal medication and where self-administration is not possible, another nominated person or health practitioner could administer the medication.

I indicate again that we are not supportive of this amendment.

Hon MARTIN PRITCHARD: I have been trying to follow this; I think I am getting a bit brain dead!

In the interpretation division at the front of the bill, under "Terms used", I am just wondering why "nurse practitioner" is not included within "administering practitioner". Is there some reason it is not there? Although it says "unless the contrary intention appears", it seems to be a bit of an oversight. If it is intended that a nurse practitioner is to act as an administering practitioner, I would have thought it would be included in the interpretation.

Hon STEPHEN DAWSON: Under "Interpretation", clause 5(b) refers to —

> a person to whom the role of administering practitioner is transferred …

That person can be both a nurse practitioner or another medical practitioner.

Hon MARTIN PRITCHARD: I understand that if it is actually going to be a nurse practitioner, a transfer form will need to be filled out.

Hon STEPHEN DAWSON: For another nurse practitioner or another medical practitioner, a form will need to be filled out.

Hon MARTIN PRITCHARD: The clause envisages the coordinating practitioner as being the administrating practitioner. If they then get a nurse practitioner to fulfil that role, will a form need to be filled out, as suggested in clause 16(2)?

Hon STEPHEN DAWSON: It could have been included in clause 5, but it is not needed because of the way clause 53 is worded.

Hon MARTIN PRITCHARD: Actually, I do not have a problem with the nurse practitioner fulfilling the role. I just wanted to make sure; I was trying to go through the bill and the amendments. The nurse practitioner would obviously have the right to refuse as a conscientious objection, I presume?

Hon Stephen Dawson: By way of interjection, they would.

Hon RICK MAZZA: I did not get an answer to the question I asked earlier about the rationale behind a nurse practitioner requiring only two years' experience, whereas under clause 16(2) a medical practitioner requires 10 years' experience.

Hon STEPHEN DAWSON: The member referred earlier to a general practitioner. A general practitioner is captured by clause 16(2)(a), which provides for a medical practitioner who —

> 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 …

That would be a general practitioner. Sorry, that clause has been amended, so it is clause 16(2)(a)(i), which is the same as the previous clause 16(2)(a). I had a conversation earlier with the Leader of the House, Hon Sue Ellery, about the suggestion of having a large bill, and that was a good suggestion for future bills. I will certainly take that issue away and encourage that to happen in the future, if it is possible. I think the Clerk advised that work would need to be done by parliamentary counsel, but we will work that out.

Hon Martin Aldridge interjected.

Hon STEPHEN DAWSON: Honourable member, I am indicating that I think it was a good suggestion. I am happy to take it away and see if it might be able to happen in the future.

A nurse practitioner needs to have two years' experience as a nurse practitioner, but they also must have completed an approved postgraduate master's degree. In Australia, a registered nurse must have 5 000 hours of advanced

clinical experience before they are eligible to be endorsed as a nurse practitioner by the Nursing and Midwifery Board of Australia. That is a significant amount of training that needs to take place.

Hon Nick Goiran interjected.

Hon STEPHEN DAWSON: It is a significant amount of training, and we are suggesting—as others have, indeed, suggested—that it would be appropriate for a nurse practitioner to undertake this role.

Hon MARTIN ALDRIDGE: I refer to a point raised by Hon Rick Mazza with regard to the differential between years of service. The point Hon Rick Mazza raised is that there is a distinction between a practitioner who is assessing a patient, either as a coordinating practitioner or a consulting practitioner, and a practitioner who is administering. This practitioner is not someone who is assessing the patient to make sure they are eligible under the legislation; they are performing a very different function.

Hon STEPHEN DAWSON: The member is correct, but they are still capable of assessing decision-making capacity.

Committee interrupted, pursuant to standing orders.

[Continued on page 9552.]

Sitting suspended from 4.14 to 4.30 pm