VOLUNTARY ASSISTED DYING BILL 2019

Committee

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

Clause 4: Principles —

Committee was interrupted after the amendment moved by Hon Martin Aldridge had been partly considered.

Hon MARTIN ALDRIDGE: I will provide some final remarks. As I said before, I seek the support of the committee on this substantive amendment that we have returned to. I understand that some members have some concerns around the state being obligated to, or involved in, the service provision of voluntary assisted dying. I am sorry that I cannot help them with that concern. If that is a concern, I think the only course of action for those members is to oppose the bill, because, at the end of the day, this is a state-sanctioned scheme. The state will be involved in the implementation of the voluntary assisted dying scheme in many respects.

Hon Nick Goiran indicated that he would oppose the amendment in its current form. He raised the issue that without the inclusion of palliative care in this amendment, what message would it send to regional Western Australians? The message that we send to regional Western Australians on palliative care is outlined in clause 4(1)(d). It states —

> a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life;

The message that my amendment sends to regional and remote Western Australians is that this chamber and this government respects their right to access this scheme, and acknowledges the government's obligation and, indeed, commitment to provide access to this scheme. Opposing this amendment would send a message to the contrary.

Amendment put and passed.

Hon MARTIN PRITCHARD: I move —

> Page 3, line 18 — To delete "abuse;" and substitute —
>
> abuse or coercion;

Hopefully, I will not have to spend much time on this amendment. I do not think this will be overly controversial. I acknowledge that coercion is dealt with within the bill, but we are now talking about the principles of the bill and I think it is very important to send a message that neither abuse nor coercion is acceptable. I turn my mind to the Minister for Environment's second reading speech. It states —

> Part 1 of the bill sets out the principles and the key themes for voluntary assisted dying in Western Australia. The principles will serve as a guide in interpreting and applying the bill. They reflect the importance of giving people genuine choice and autonomy over their decision-making, while also recognising the need to protect individuals who may be vulnerable to undue influence.

It seems to me that it would be appropriate to have that reflected in the principles.

Hon STEPHEN DAWSON: Can I indicate that the government will accept Hon Martin Pritchard's amendment? Abuse is a very wide concept that includes financial, emotional, psychological and physical abuse. It includes aggression. It encapsulates the notion of the wrongness of using another human being as a means to an end—as a commodity rather than as a valued individual. Coercion is the practice of persuading someone to do something by use of dishonesty, force or threat. The term "abuse" is intended to include coercion. However, Hon Martin Pritchard's proposed amendment will not weaken the principle. The term "coercion" is consistently used in the bill. Both "coercion" and "abuse" are terms commonly understood by the community. Much of the debate has centred around how we must protect the vulnerable from coercion. The government is therefore content to include the word "coercion" for the sake of completeness and clarity, and thus supports the amendment moved by the honourable member.

Hon NICK GOIRAN: The amendment before the house is one moved by Hon Martin Pritchard, who seeks to expand this principle by including the words "or coercion" in addition to "abuse". I support the amendment moved by the honourable member. Members will see that immediately underneath the member's amendment is an amendment in my name in similar but further expanded terms, by which I seek to also include the words "duress or undue influence". It was interesting to hear the explanation provided by the honourable member, who referred to some material that included the use of the phrase "undue influence". I guess that goes to the heart of why I have also sought to expand the language in this principle. I am inclined to move an amendment to the member's amendment so as to facilitate progress and so that we do not have to move my amendment at 55/4. I will do that in a minute by seeking to insert the words "duress or undue influence", but before I do that, I will perhaps ask some general questions on this principle. Minister, who has the responsibility to protect persons from the abuse outlined in this principle?

Hon STEPHEN DAWSON: Everybody, honourable member. The bill does not prescribe responsibility.

Hon NICK GOIRAN: Clause 4(1) states —

> A person exercising a power or performing a function under this Act must have regard to the following principles —

Paragraph (i), which is the one we are looking at, states —

> there is a need to protect persons who may be subject to abuse;

Is that a responsibility for persons who are exercising a power or performing a function under this legislation, or is it, as the minister said, every person in Western Australia?

Hon STEPHEN DAWSON: I am advised that the principle is aspirational for everyone, but in the context of this bill, a person who is exercising a power or performing a function under the legislation must have regard to the principles.

Hon NICK GOIRAN: Looking ahead to the amendment standing in my name at 55/4, as I indicated, I am probably inclined to move an amendment to the one proposed by Hon Martin Pritchard. I can provide a detailed explanation for the reason for that, but perhaps if we are looking to make some progress, can I get an indication of what the government's position is on the addition of the words "duress or undue influence"? If we are all on the same page, I am happy to move on.

Hon STEPHEN DAWSON: I am sorry to advise the honourable member that we are not all on the same page and we do not support the amendment to insert the words "duress or undue influence". The honourable member is going to ask why, so why do I not outline the reasons now before I sit down? "Duress" means that someone is doing something against their will and that perhaps threats, violence, constraints or other action is used to coerce someone into doing something against their will or better judgement. The meaning or intention of "duress" is captured by the use of more easily understood terminology in the bill such as the term "coercion", and "abuse" more widely. I am advised that it is unwarranted to include the additional words. I am advised "undue influence" is legalistic terminology reflected in the offence provisions of the bill at clauses 99 and 100. It denotes when a person uses improper influence that deprives another person of freedom of choice or substitute another's choice or desire for the former person's own. It is a legal term that is understood by the learned profession; however, it is less familiar to the general community. Both "coercion" and "abuse" are terms commonly understood by health practitioners and the wider community, and those are appropriate for use in the principles clause of this bill. The amendments proposed by Hon Nick Goiran could add unduly technical legalistic words that do not advance the broad effect of the words proposed by Hon Martin Pritchard, which were accepted by the government.

Hon NICK GOIRAN: Given that explanation, I move the following amendment to the amendment of Hon Martin Pritchard at 1/4 —

> to insert after "coercion" —
>
> , duress or undue influence

Hon NICK GOIRAN: Notwithstanding the comments made by the minister, which seem to indicate that the principles clause is really just for the general public but if it gets too legalistic, it will get too complicated for the general public, so we cannot insert these words, I draw members' attention to clause 4(2), which states —

> In subsection (1), the reference to a person exercising a power or performing a function under this Act includes the Tribunal exercising its review jurisdiction in relation to a decision made under this Act.

The entirety of clause 4 is directed at persons exercising a power or performing a function under the act. With all due respect, it is a red herring to suggest that if the language is too complicated or too legalistic for the community, somehow it should not be incorporated into this amendment.

The amendment before us seeks to strengthen what the Minister for Health, Mr Cook, has described. I quote from page 6330 of the *Hansard* of 3 September 2019, when he said —

> … one of the key principles of the legislation; no-one who would be accessing voluntary assisted dying is in any way subject to abuse.

This key principle is currently worded in the bill. Only the term "abuse" is employed. I noted the concerns that were raised by the member for Hillarys in the other place on the limitations of this term for the purposes of this key principle. I quote pages 6330 and 6331 of the *Hansard* of 3 September 2019, when the member for Hillarys said —

> "Abuse" is quite a strong term. There are a number of concerns about people's influence on patients' decisions, such as coercion, duress, undue influence and the like. A lot of those terms have specific legal meaning, which is not defined by reference to the word "abuse". I am not aware of any legislative provision in Western Australia or any precedent that defines coercion or duress as abuse. I am simply concerned about where the boundary will be drawn for what constitutes abuse and what is considered bad

> behaviour that may not necessarily reach the point of being abuse. In asking that question, I seriously ask the minister to contemplate broadening this definition, because, as I said, abuse has quite a high bar to go over to be proven. Alternatively, I suggest an inclusive definition that says something along the lines of "abuse includes duress, coercion and undue influence". Otherwise, irrespective of whether these are principles or enforceable legislative provisions, we leave this act open to question marks about serious matters that could have strong influence on a person who is contemplating making these sorts of decisions that may not necessarily reach the point of being considered abuse but would still be considered to be having an unfair and undue influence on that individual.

The member for Hillarys went on to say —

> We all agree that no-one wants anyone to be subject to abuse, but the point here is that there are levels of pernicious behaviour towards a vulnerable individual that may not necessarily be considered to be abuse; they may be considered to be slightly lower than the benchmark for abuse, but still highly influential and pejoratively influential on an individual. That is the point I am making. I have made it very clear that I do not feel comfortable supporting this legislation, but I still want it to be as safe as humanly possible. I think that limiting the types of influences that a person is protected from to abuse is setting the benchmark way too high, because, as I said, I know of no legal jurisdiction that defines duress as being abuse or that defines coercion as being abuse. If it is litigated, there may well be a finding that there needs to be a level of coercion or duress before it is abuse. We are talking about principles here and I would have thought that broader and more inclusive language would have been used to assuage the fears and concerns of people, which I have, that this is highly prescriptive and highly dangerous legislation that does not provide enough protection for vulnerable individuals.

The wording proposed in my amendment also sits well with the offence provisions in part 6 of the bill. For example, clause 99 states —

> (2) A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person —
>
> (a) to make a request for access to voluntary assisted dying;

I also draw to members' attention clause 100, which provides —

> A person commits a crime if the person, by dishonesty, undue influence or coercion, induces another person to self-administer a prescribed substance.

In addition, the use of the word "duress" in legislation in Western Australia is not unique. We would not be the first chamber to do this. I draw members' attention to sections 18(5) and 77(2) of the Adoption Act 1994 and section 27(2) of the Surrogacy Act 2008, which also use the word "duress". As for the term "undue influence", the same applies. This would not be unique to this particular legislation. I draw to members' attention section 76 of the Workers' Compensation and Injury Management Act 1981 and section 15(2)(d) of the Home Building Contracts Act 1991, both of which use the term "undue influence". For those reasons, I seek the support of members to expand this principle to include the words "duress or undue influence".

Division

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

Ayes (12)

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

Noes (22)

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

Amendment on the amendment thus negatived.

Amendment put and passed.

Hon NICK GOIRAN: We have just considered the principle in paragraph (i). The next on the list is paragraph (j), which concerns respect. There is an amendment standing in my name on the supplementary notice paper, but before we get to that, I have one or two questions about paragraph (j). What is intended by the phrase "personal characteristics"?

Hon STEPHEN DAWSON: Honourable member —

Hon Nick Goiran: It must be complicated!

Hon STEPHEN DAWSON: No. There are a few things I could refer to; that is all. It will not be a comprehensive list, but I can give the member an example. It might allude to a person's personal appearance, their physical features, the effects of ageing on them, how they choose to dress, and possibly whether they are introverted or extroverted— those types of things. It is difficult to give the member a definition, but it includes those things.

Hon NICK GOIRAN: I thank the minister for that explanation. I think that further underscores the appropriateness of this principle, which reads —

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

Indeed, we might note that "all persons" would include that all members of Parliament have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

The minister can see my proposed amendment 56/4 on the supplementary notice paper. Before I move that amendment, the purpose of it is really to capture organisations. It strikes me that this principle shows respect for the conscientious objection of individuals but not necessarily of organisations. Is the minister in a position to give an indication of the government's view on that?

Hon STEPHEN DAWSON: I can indicate that we are not supportive of the amendment. Firstly, the honourable member's proposed amendment refers to "registered health practitioners". Obviously, we have debated this issue previously, so I will not go over that again, because I think the member understands where I am coming from on that. Secondly, on extending the principle to include organisations, certainly I have said before that this bill is patient centred and reflects the choice of individuals to participate or not participate in the voluntary assisted dying process. It is not organisation focused. For that reason, we do not support the inclusion of the word "organisation".

Hon NICK GOIRAN: I note what the minister has said. I respect the fact that my proposed amendment covers two parts. The first is the insertion of the word "registered" in front of "health practitioners", and we have had a debate about that. I do not want this amendment to fail because of the insertion of the word "registered" before the phrase "health practitioners", given that the rest of the principles currently state "health practitioners" for the reasons we have debated earlier this afternoon. I am inclined to amend the proposed amendment, given I have not actually moved it yet, that stands in my name on the supplementary notice paper by not proceeding with the use of the word "registered" in the first line. I am inclined to proceed with the rest of my proposed amendment. I move —

> Page 3, lines 19 to 21 — To delete the lines and substitute —
>
> (j) all persons, including health practitioners, and organisations have the right to be shown respect for their personal or organisational culture, religion, beliefs, values and characteristics.

Hon STEPHEN DAWSON: I had indicated that we would not support both parts of the original amendment, but we certainly do not support how it has been moved now, as it still includes the issue of organisations. As many of us would be aware, the culture of an organisation may not be reflected by the individuals within it. This bill is patient centred and reflects the choice of individuals to participate or not participate in the voluntary assisted dying process, from the patient to the medical practitioner, who may be asked to be an assessing practitioner; to a pharmacist, who may be asked to supply the substance; to a nurse practitioner or medical practitioner who administers the substance to the patient. These are actions of individuals. As such, the government will not accept a change to this principle. The intention of the existing provisions in the bill directed at health practitioners is that corporations, including faith-based institutions, cannot be compelled to participate in the VAD process. They are able to object to participating in the voluntary assisted dying processes for any reason, including but not limited to conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations that do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

Hon NICK GOIRAN: By way of explanation, the amendment that I have moved strengthens the conscientious objection principle contained in clause 4(1)(j) by extending the right to conscientious objection to not only individual practitioners, but also organisations that provide health services. This amendment is supported by statements made by the minister in the other place, when he said —

> … I am informed that the faith-based hospitals are able to object to participating in the voluntary assisted dying processes for any reason, including, but not limited to, conscientious objection.

I am quoting from the Legislative Assembly *Hansard* of 3 September 2019 at page 6337. I also note the same remarks made by the minister in his second reading speech found at pages 6313 and 6314. This amendment makes explicit what the minister reiterated more than once in the Assembly debate. In that debate the minister alluded to the transfer of patients, and I note that at page 6337, *Hansard* records these remarks by the honourable minister on 3 September this year —

> A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

We know from other jurisdictions, including Canada, that conscientious objection is a live issue. Professor Jocelyn Downie writes that the Provincial–Territorial Expert Advisory Group in Canada recommended that governments establish a duty to transfer care from conscientiously objecting providers and that conscientious objection remains a key outstanding legal issue to be resolved in Canada. This can be found in a *QUT Law Review* article entitled "Medical Assistance in Dying: Lessons for Australia from Canada". It is unclear from the minister's comments in the other place about the transfer of patients whether it goes so far as to constitute a duty for conscientiously objecting providers to transfer care, but in any event, in her article Professor Downie writes —

> It is also essential to develop a transfer of care system if any conscientious objection by providers and/or publicly funded health care institutions will be permitted. Many provinces and territories in Canada have set up such systems and as a result some patients can access —

Medical assistance in dying —

> … even when their own health care providers object to it.

This amendment would make it clear that conscientious objection by providers and/or publicly funded healthcare institutions will be permitted in Western Australia. It is then, of course, up to the government of the day whether it sees fit to develop a transfer of care system.

Division

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

Ayes (7)

Hon Martin Aldridge	Hon Simon O'Brien	Hon Aaron Stonehouse	Hon Ken Baston *(Teller)*
Hon Nick Goiran	Hon Charles Smith	Hon Colin Tincknell	

Noes (25)

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

Amendment thus negatived.

Clause, as amended, put and passed.

Clause 5: Terms used —

Hon NICK GOIRAN: Clause 5 obviously includes all the terms that have been defined in the bill. When a term has been used on more than one occasion, it is found in clause 5. When a term has been used on only one occasion, it is found in the discrete clause. There is nothing particularly unusual about that. For the sake of the exercise, I thought that my questions might be usefully asked in alphabetical order. I will start with the role of the CEO. Who holds the position of CEO of the public service department that is principally assisting in the administration of this bill?

Hon STEPHEN DAWSON: It is the director general of the Department of Health. Is the member asking who the individual is?

Hon NICK GOIRAN: No. Why was that particular director general chosen as the appropriate one to act as CEO for the purposes of this bill?

Hon STEPHEN DAWSON: It is because it is a health-related bill, honourable member.

Hon NICK GOIRAN: What duties will this person have under this bill?

Sitting suspended from 6.00 to 7.30 pm

Hon STEPHEN DAWSON: Before we broke for dinner, Hon Nick Goiran asked me a question about the chief executive officer. I can advise that the CEO is responsible for the facilitation of a number of processes under the bill. The processes relate to administrative and operational matters, the purpose of which is to enable lawful implementation. Functions conferred on the CEO reflect the fact that administrative responsibility for the bill will be undertaken by the Department of Health. The powers that the CEO has are mentioned at a number of places throughout the bill, including, for example, in clause 7, the approval of the voluntary assisted dying substance, and at clause 95, receiving a copy of State Administrative Tribunal reasons for decisions. I think the CEO is mentioned at 16 to 20 places, according to my count during the dinner break.

Hon NICK GOIRAN: According to the minister's advice to the chamber, albeit a rough count, about 16 to 20 provisions in the bill confer duties, responsibilities or powers upon the CEO, which is the director general of Health. Can the minister advise the chamber whether that person would have a right to conscientious objection?

Hon STEPHEN DAWSON: I am advised that the CEO could personally conscientiously object, but, as the CEO, he or she would be required to undertake their role as outlined in the bill.

Hon NICK GOIRAN: I think the minister mentioned earlier that on his rough count something in the realm of 16 to 20 provisions confer certain duties and the like upon the CEO. If the CEO personally objects to having to perform one of these functions or powers, what recourse would be available to that person?

Hon STEPHEN DAWSON: I am getting further advice, but I will start. The CEO is a public servant. Clause 9, regarding conscientious objection, is for registered health practitioners. I am further advised that the CEO can delegate for a number of reasons, such as administrative necessity. An appointment to the role of chief executive officer of the Department of Health requires that the appointee is prepared to undertake all lawful functions of the office.

Hon NICK GOIRAN: Would it not be lawful to conscientiously object?

Hon STEPHEN DAWSON: As I indicated, clause 9 provides for the conscientious objection of a registered practitioner; it does not provide for a CEO.

Hon NICK GOIRAN: Apart from the fact that the CEO might be a registered health practitioner, I would ask the minister to comment on that. Secondly, I draw to the minister's attention clause 4(1)(j), which states —

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

In light of that, would not any CEO of Health have a right to conscientious objection, quite apart from the fact that the CEO might be a registered practitioner?

Hon STEPHEN DAWSON: No; that is not the case. We would certainly show respect to the CEO's culture, religion, beliefs, values and personal characteristics, but there is no requirement—again, I draw the member's attention to clause 9—that provides for conscientious objection of a registered health practitioner. The member went further and asked: what if the CEO is not only the CEO but also a registered practitioner? I am advised that his or her role—I will use "his"; excuse me, if anybody takes offence, because it is a he at the moment—as CEO is quite different from any role he may undertake as a registered health practitioner.

Hon NICK GOIRAN: Minister, is a right to conscientious objection only a statutory right; in other words, if it does not appear in the bill, then Western Australians do not have a right to conscientious objection?

Hon STEPHEN DAWSON: We are dealing with clause 5. The member has pointed out that "CEO" means the chief executive officer of the department, but the questions he is asking now go to a different place. I think they are probably outside the scope of this clause.

Hon NICK GOIRAN: Mr Deputy Chair, that is usually the answer we get when a cogent response is not available for the chamber. I am quite happy, minister, to pick that up again at clause 9 if that is what the minister would prefer. What I do not want is to get to clause 9 and ask other questions about the CEO and be told that I really should have asked that under clause 5. If it is about conscientious objection, I am happy to defer those questions to clause 9, if that is the minister's preference. Is the minister able to take questions at this point about the CEO's power to delegate, which he referred to, or would the minister prefer that to be dealt with under a different clause?

Hon STEPHEN DAWSON: I can take questions about the CEO's delegation now.

Hon NICK GOIRAN: The minister indicated earlier that the CEO has the capacity to delegate, including for reasons such as administrative necessity. Is that a power to delegate that is found in this bill or is it in another piece of legislation? Wherever that power is found, whether it be here or another place, what is the reference to administrative necessity?

Hon STEPHEN DAWSON: The bill does not contain a specific clause regarding the delegation power of the CEO. The intent is that the CEO will have the final sign-off for any duties under the bill. However, if we do wish the CEO

to delegate, as may be an administrative necessity over time, we may rely on section 9 of the Health Legislation Administration Act 1984 as the overarching delegation power. This is because that act applies to the acts, the administration of which is committed by the Governor to the Minister for Health, and the administration of the VAD act will be committed to the Minister for Health.

Hon NICK GOIRAN: Looking at the terms in clause 5, I take the minister to the term "final review", which is found on page 5 at line 20. Final review refers to the review conducted under section 50(1)(a) and is the last item listed under the request and assessment process in clause 5. Is the final review the last time at which the patient's capacity, the voluntariness of the request and the enduring nature of the request are assessed?

Hon STEPHEN DAWSON: No.

Hon NICK GOIRAN: At line 20, it states —

> ***final review*** means a review conducted under section 50(1)(a) by the coordinating practitioner for a patient;

Clause 50 states —

> (1) On receiving a final request made by a patient, the coordinating practitioner for the patient must —
>
> (a) review the following in respect of the patient —
>
> (i) the first assessment report form;
>
> (ii) all consulting assessment report forms;
>
> (iii) the written declaration;
>
> and
>
> (b) complete the approved form … in respect of the patient.

If, minister, that is not the final time at which a patient's capacity, the voluntariness of the request and the enduring nature of the request are assessed, when is the final time that that is done?

Hon STEPHEN DAWSON: If practitioner administered, their capacity, voluntariness and enduring nature are assessed again before the substance is administered.

Hon NICK GOIRAN: The process that the minister just described for practitioner administration sounds like a final review, but apparently it is not a final review. Why do we call this a final review when the minister has indicated that at the time of administration there will be another assessment—another review—undertaken of the patient's capacity, the voluntariness of the request and the enduring nature of the request?

Hon STEPHEN DAWSON: It is a final review before they make an administration decision.

Hon NICK GOIRAN: I will move on to the definition of "medical practitioner". This is interesting given the discussion that we had earlier this afternoon on the definition of a "registered health practitioner", which is not to be confused with a health practitioner. In clause 5, the definition of a medical practitioner includes the statement "other than as a student". This is not included in the definition of a medical practitioner that is contained in the following Western Australian acts: Adoption Act 1994, Alcohol and Other Drugs Act 1974, Anatomy Act 1930, Bail Act 1982, Blood Donation (Limitation of Liability) Act 1985, Combat Sports Act 1987, Corruption, Crime and Misconduct Act 2003, Cremation Act 1929, Criminal Code Act Compilation Act 1913, Criminal Property Confiscation Act 2000, Diamond (Argyle Diamond Mines Joint Venture) Agreement Act 1981, Fire and Emergency Services Act 1998, Firearms Act 1973, Gender Reassignment Act 2000, Health (Miscellaneous Provisions) Act 1911, Health Services Act 2016, Human Reproductive Technology Act 1991, Human Tissue and Transplant Act 1982, Industrial Relations Act 1979, Mental Health Act 2014, Minimum Conditions of Employment Act 1993, Misuse of Drugs Act 1981, Private Hospitals and Health Services Act 1927, Prostitution Act 2000, Public Health Act 2016, Rail Safety National Law (WA) Act 2015, Road Traffic Act 1974, Teacher Registration Act 2017, Transport (Road Passenger Services) Act 2018 and Workers' Compensation and Injury Management Act 1981.

In light of that, can the minister please explain why the definition of "medical practitioner" includes the bracketed phrase "other than as a student"?

Hon STEPHEN DAWSON: The reason is that we require medical practitioners to have a certain level of skill and experience, as set out in clause 16 of this bill.

Hon NICK GOIRAN: Minister, are medical practitioners not required to have a certain level of skill and experience for all of those other acts that I read out?

Hon STEPHEN DAWSON: I cannot comment on why other acts are written the way they are written, but what I can comment on is the bill that is before us. We require a certain level of skill and experience for medical practitioners who will undertake a coordinating or consulting role under this bill.

Hon NICK GOIRAN: Upon whose advice was it deemed necessary to add the phrase "other than as a student" to the definition of "medical practitioner" in light of the fact that it is not included in those other Western Australian statutes?

Hon STEPHEN DAWSON: I am advised that it was a policy intent of the Ministerial Expert Panel on Voluntary Assisted Dying, at recommendation 15. Following that, a policy decision was made to include what we have included in the bill before us.

Hon NICK GOIRAN: The ministerial expert panel recommended this. Where do we find that in the final report of the Ministerial Expert Panel on Voluntary Assisted Dying?

Hon STEPHEN DAWSON: It is on page 60 of the ministerial expert panel report, under MEP recommendation 15. I refer the member to the section titled "Policy intent" below that recommendation.

Hon NICK GOIRAN: The policy intent referred to at page 60 states —

> To ensure that the medical practitioners seeking to become co-ordinating or consulting practitioners for the purpose of voluntary assisted dying are only those that are appropriately qualified, skilled and experienced.
>
> To ensure that there is appropriate access to voluntary assisted dying across the geographically diverse state of Western Australia.
>
> To ensure that trainees or junior medical practitioners do not able —

I presume that is supposed to read "are not able" —

> to be either a co-ordinating or consulting practitioner for voluntary assisted dying.

How is the policy intent to ensure that junior medical practitioners are not able to be a coordinating or consulting practitioner addressed in this definition of "medical practitioner", which excludes students?

Hon STEPHEN DAWSON: I am getting further information on that, but while I do, I draw the member's attention to the fourth paragraph on page 58 of the report, which states —

> In considering the question of medical practitioner qualifications and experience, the Panel was clear that this is not an appropriate task to be undertaken by junior medical practitioners or by medical practitioners in training. Being a co-ordinating or consulting practitioner for a person who has requested voluntary assisted dying is a significant responsibility and poses ethical and clinical practice considerations for these practitioners. This is not an appropriate responsibility to place on learning or inexperienced practitioners.

A junior medical practitioner cannot be a coordinating or consulting practitioner by virtue of clause 16 of the bill.

Hon NICK GOIRAN: The minister stated that clause 16 of the bill carves out junior medical practitioners. Is that on the basis that certain criteria need to be held by those medical practitioners; for example, they have to hold specialist registration, which by definition would mean they would no longer be junior; or if they have general registration, they have to have been practising for at least 10 years; or if they are overseas-trained specialists, there are certain other requirements, including the fact that the CEO would have to approve their participation? That seems to make a lot of sense to me and it has my support, but it is not clear to me, when we come back to this definition of "medical practitioner", that there are not any other duties, tasks or obligations that fall upon a medical practitioner in Western Australia as a result of this bill. It is clear, because of what the minister has just pointed out, that those junior medical practitioners cannot be coordinating or consulting practitioners. One question that immediately arises is: could they be an administering practitioner? I assume the answer to that is no, but be that as it may, is there anything else in this bill that falls upon medical practitioners generally? If I can give the minister an example, I believe somewhere in the bill there is a requirement for medical practitioners to provide information to patients. Even if they conscientiously object, they are still required to provide some information to patients. Would that fall upon any medical practitioner in Western Australia, including junior ones?

Hon STEPHEN DAWSON: The answer is yes.

Hon NICK GOIRAN: So, yes, there is some obligation on medical practitioners. Let us be clear. Yes, a junior medical practitioner has responsibilities or duties under this act. I am happy to take it by interjection, if that assists.

Hon Stephen Dawson: Yes.

Hon NICK GOIRAN: Yes; okay. This is why the definition of "medical practitioner" is so important. The definition before us at the moment says —

> ***medical practitioner*** means a person registered under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession (other than as a student);

Students are carved out of this definition, and I think that is entirely appropriate for the reasons that we have discussed, as also outlined by the ministerial expert panel at pages 58 and 60 that the minister referred us to. However, the ministerial expert panel also said that it would not be appropriate for junior medical practitioners to

be involved in this process, yet I understand from the minister that we are still requiring Western Australian junior medical practitioners to have certain duties under this bill. Why is that appropriate?

Hon STEPHEN DAWSON: We do not believe that a junior doctor is at a level to act as a coordinating or consulting practitioner, but they would have more than enough skill to report a first request to the board and to give a patient information that is approved by the CEO.

Hon NICK GOIRAN: Perhaps this is an appropriate time for me to flag a concern that the government and other interested members might take on. While reading this for our consideration of new clause 9A, which was proposed by Hon Martin Pritchard, I noticed today that we have amendments to clauses 4, 5, 8 and new clause 9A in the minister's name. There has been some publicity about that today because this is part of the latest round of amendments that the government has seen fit to put forward. This really deals with what some people have described as the Buti amendment. I draw to the minister's attention and to those members who are particularly interested in the Buti amendment and the like that there is a significant difference between what is proposed by Hon Martin Pritchard and what is proposed by the government. Hon Martin Pritchard effectively copied the amendment moved by the member for Armadale in the other place by prohibiting any registered health practitioner from initiating discussions. However, I note that there is an amendment in the minister's name that would allow a registered health practitioner.

The DEPUTY CHAIR (Hon Matthew Swinbourn): Member, can you bring this back to the clause.

Hon NICK GOIRAN: It requires some elaboration, Mr Deputy Chair.

The DEPUTY CHAIR: I am giving you that, but I just want you to bring it back.

Hon NICK GOIRAN: I am endeavouring to do so now.

As we have identified, the definition of "medical practitioner" includes junior doctors. It does not include students. I am foreshadowing now that this definition of "medical practitioner" could create an issue when we get to new clause 9A. We will have that discussion at new clause 9A, but I suspect that it will come back to this definition of "medical practitioner" because the definition includes junior doctors, who would then have the power under the minister's amendment to initiate discussions with patients, whereas under Hon Martin Pritchard's amendment, they would not be able to do that. We can have that more detailed discussion under new clause 9A. I wanted to bring that to the minister's attention in the spirit of understanding that the government has placed an amendment on the supplementary notice paper.

It has been a highly contested issue. It is an issue that a number of members have an interest in. It will ultimately have at its genesis—at its heart—this definition of "medical practitioner", which includes junior doctors. As the minister kindly drew to our attention, the ministerial expert panel has said that it is not appropriate to place that responsibility on learning or inexperienced practitioners because it poses ethical and clinical practice considerations for these practitioners. I accept that in the context of those remarks by the ministerial expert panel, it is about those people being coordinating or consulting practitioners, but the ethical considerations will remain the same. If they are going to initiate a conversation with a patient, it is going to be the same. I just wanted to flag that. It is not clear to me how that can be addressed at this particular juncture, but perhaps it is something that the government can take away.

In light of the amendment that the government has foreshadowed, I guess I am asking the minister, the minister's advisers and the health minister whether it is appropriate for a junior practitioner to be able to initiate that discussion. People may have a view about whether that is appropriate. I am just flagging that now because the words in the amendment would imply that it is appropriate. I am not sure that that is consistent with the policy intent of the ministerial expert panel's recommendations or, in any event, whether it is appropriate.

On that note, I want to cover one other theme that deals with an issue about the definition of "simple offence" that arose in the other place. Once I have dealt with that, I propose to start making my way through some of the amendments to clause 5 on the supplementary notice paper. I draw to the attention of those members who have amendments to clause 5—for example, Hon Rick Mazza, Hon Charles Smith, Hon Martin Aldridge and the minister—that in the discussion that I had with the Clerk, I learnt that if their amendment to clause 5 is effectively a consequential amendment to a more substantive amendment later, it is open to them to not move it and leave it on the supplementary notice paper and we can always come back to it if their substantive amendment gets up later, but it will require the recommittal of the bill. I draw that to the attention of members and, in particular, the clerks assisting, because there will be some circumstances when I will indicate that I will not move my amendment, notwithstanding the fact that it is on the supplementary notice paper at this time, but I do not necessarily want it to be removed. I think that will assist the more efficient progress of clause 5, for what it is worth.

Having made those remarks, I have some questions about whether a definition of "simple offence" should be put into the bill. This arises from discussion that took place in the other place. Queries were raised about this, in

particular whether it would be appropriate to make it clear that we are referring to a term alleged to be in the Criminal Code. I draw to the minister's attention this exchange that took place between the member for Hillarys and the Minister for Health. Mr Katsambanis said —

> Clause 110 is headed "Who may commence proceedings for simple offence".

Hon Stephen Dawson: It wasn't in the Criminal Code. I think the minister might have misspoken. It is in the Interpretation Act 1984.

Hon NICK GOIRAN: Does the minister want to clarify that?

Hon STEPHEN DAWSON: My advisers tell me that section 67 of the Interpretation Act 1984 sets out that offences are of two types: indictable offences, which are crimes and misdemeanours; and simple offences, which are offences that are not designated as a crime or misdemeanour and are dealt with in the Magistrates Court.

Hon NICK GOIRAN: That is not what the Minister for Health said to the other place.

Hon Stephen Dawson: My advisers tell me that he may have misspoken.

Hon NICK GOIRAN: He may have misspoken—right; okay. I feel sorry for the members in the other place. I note that there was quite a bit of misspeaking then, because the Minister for Health said, and I quote from *Hansard* of 18 September at page 7034 —

> I am happy to provide the information. The member will probably be familiar with it.

He was obviously speaking to the member for Hillarys —

> I am informed that a simple offence is defined in the Criminal Code. They are offences such as not lodging a form, which has a fine of up to $10 000. From that perspective, it is those types of offences. Simple offences are defined in the Criminal Code.

It appears that that information was not correct. I think the Minister for Environment referred to section 67 of the Interpretation Act. Is that where the definition of "simple offence" is found, and do I understand him to be saying that there is no definition in the Criminal Code?

Hon STEPHEN DAWSON: Yes, and the member is correct.

Hon NICK GOIRAN: I move —

> Page 4, line 2 — To delete "substance," and substitute —
>
> poison,

Notwithstanding the comments I made to members earlier that it is possible to leave an amendment on the supplementary notice paper and deal with a more substantive one later—this is one that could be dealt with in that way—I want to deal with it at this time. The context is that, for better or worse, this amendment on the supplementary notice paper is one of a massive number of consequential amendments. I would rather that we dealt with this now than for it to continue to be on the supplementary notice paper. The context of that is the intemperate remarks of the Premier of Western Australia. When I lodged this amendment on the supplementary notice paper, the Premier thought it fit to immediately run, almost in a hysterical fashion, to the media and pronounce to all and sundry that I was moving some 357 amendments. I was very disappointed by those remarks made by a very experienced parliamentarian, because that experienced parliamentarian knows full well the distinction between a primary amendment and a consequential amendment. Although the quantum of amendments was probably 357, as the Premier alleged, nevertheless he sought only to mislead people as to —

Hon Alannah MacTiernan: He did not. He sought to reflect what was really going on.

The DEPUTY CHAIR: Order, member!

Hon Donna Faragher interjected.

Hon Alannah MacTiernan interjected.

The DEPUTY CHAIR: Member and minister, the member will be heard in silence.

Hon NICK GOIRAN: Thanks, Mr Deputy Chairman. It is disappointing to get that interjection from another very experienced parliamentarian, who also knows the difference between a consequential amendment and a primary amendment. Nevertheless, because of the hysteria caused by the Premier and his intemperate remarks, I think it is best that we deal with this amendment now rather than at the more preferable place, which would be at clause 7. This is a consequential amendment that would flow from the proposed amendment to clause 7 that is on the supplementary notice paper under my name. At clause 7, I seek to substitute "substance" with "poison". As I have indicated, a great number of consequential amendments flow from the substitution of that term throughout the bill,

the first of which is this amendment to delete "substance" and substitute it with "poison" in the definition of "administration" in clause 5.

The Minister for Health informed the other place that "substance" was adopted in the Voluntary Assisted Dying Bill 2019 to—I will quote from page 6399 of *Hansard* on 4 September 2019—"create consistency with the Medicines and Poisons Act 2014." I will say that again: it was to "create consistency with the Medicines and Poisons Act 2014." If a member was not inclined to check that information from the minister, they might be inclined to think that what he said was correct. It is a little bit like the earlier situation. The minister told the other place that "simple offence" is defined in the Criminal Code. It was not until today, 19 November, that the public record was corrected. Members in the other place were misinformed and misled by bad advice from the minister. He falsely told people that the Criminal Code contains a definition of "simple offence", but we found out today that that is not the case. When we repeatedly get bad advice like that from this health minister, who has form and history in that regard, it can be understood why some of us test these things and check them. The minister said to the other place that this is to create consistency with the Medicines and Poisons Act 2014. I would like members who are willing to intellectually wrestle and engage with this stuff and do our job as serious lawmakers to look at the Medicines and Poisons Act 2014 and tell me whether the minister in the other place was correct when he said it would create consistency, or whether it is the case that it would create inconsistency. Just on that, I draw members' attention to clause 13—a very interesting clause in this bill, which refers to the relationship with the Medicines and Poisons Act 2014 and the Misuse of Drugs Act 1981. If members read clause 13, it will probably tell them a lot about what is going on with the Minister for Health and his assertion that somehow using the word "substance" will create consistency with the Medicines and Poisons Act 2014. The truth is—the inconvenient truth for the Minister for Health—that the Medicines and Poisons Act 2014 uses a variety of terms in different contexts, including "medicines", "poisons", "drugs", and, indeed, "substances". Section 3 of the Medicines and Poisons Act 2014 defines poison as —

> … a substance that is a Schedule 2, 3, 4, 5, 6, 7, 8 or 9 poison;

Section 3 of the Medicines and Poisons Act 2014 defines a schedule 4 poison as —

> … a substance that is classified by regulations made under section 4(1) as a poison included in Schedule 4;

Section 3 of the Medicines and Poisons Act 2014 defines a schedule 8 poison as —

> … a substance that is classified by regulations made under section 4(1) as a poison included in Schedule 8;

Section 3 of the Medicines and Poisons Act 2014 also states that —

> ***substance*** includes a compound, preparation, mixture or plant;

"Substance" is an inadequate term to describe a schedule 4 or 8 drug proposed for use under this bill to cause the death of a patient. The term "poison" is more consistent with the terms defined in the Medicines and Poisons Act 2014.

I draw members' attention to the following inconsistencies within the bill before us. Why does the proposed amendment in clause 174(2) use the word "poison" when talking about the manufacture and supply of schedule 4 or 8 poisons in cases other than for the use of voluntary assisted dying, but then use the word "substance" when talking about the supply of schedule 4 or 8 poisons for voluntary assisted dying? Why also does the proposed amendment to this bill under clause 174(4) use the word "poison" when talking about the prescription of schedule 4 or 8 poisons in cases other than for voluntary assisted dying, but then again use the word "substance" when talking about the supply of schedule 4 or 8 poisons for voluntary assisted dying? The very same substance—that is, a schedule 4 or 8 poison—is referred to as both a poison and a substance. The only difference is the purpose for which the schedule 4 or 8 poison is supplied. In other words, if the schedule 4 or 8 poison is supplied for the purpose of being administered to cause the death of a patient, it is suddenly, instantaneously, no longer a poison; it is a substance. The use of the term "substance" creates inconsistency with the Medicines and Poisons Act 2014 rather than consistency, as the health minister sought to argue in the other place.

I question why there is this great desire, firstly, to sanitise the term; and, secondly, to create inconsistency. I think we need to be clear that this schedule 4 or 8 poison, depending on what is chosen by the CEO, is a poison that will cause the death of the patient.

I have to say that comments made during the debate in the other place have been incredibly unhelpful on this. I note the following remarks by the Attorney General. He said, on 5 September this year, for the benefit of *Hansard*, at page 6696 —

> … I would like to correct you that they are accessing a substance that is going to kill them. This is not right. What is going to kill them is the disease that they have. Under clause 15(c), it has to be a terminal disease that on the balance of probabilities is going to kill them within six months. Therefore, they are not accessing a substance to kill them; they are being killed by a growth within their body.

That is from the Attorney General of Western Australia on 5 September this year.

The DEPUTY CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: Clauses 57(2) and 58(2) make it very clear that the coordinating practitioner is to prescribe a substance, or, as per my amendment, a poison, "that is of a sufficient dose to cause death". That is what the bill drafted by the government says in clauses 57 and 58. This clearly refutes the statement made by the Attorney General in the other place. This amendment to substitute the term "substance" with the term "poison" dispels any notion propagated in error in debate in the other place that this schedule 4 or schedule 8 poison is akin to other medicines that a person may take. For example, the Attorney General in the other place referred to the poison as a syrup. That is found at page 6631 of *Hansard* on 5 September 2019. He also referred to the poison as a potion, which can be found at page 6637 of *Hansard* on 5 September 2019. We need to make it clear to the Western Australian public that this is a poison that will cause the death of a person when consumed or administered intravenously. The administration of the schedule 4 or 8 poison to cause the death of a person has, by the admission of the Attorney General of this state, and in contrast with his earlier suggestion that the person's death is caused by their underlying disease, the same outcome as the use of garden shed poisons to cause the death of a person. I quote from the Attorney General's remarks from 5 September 2019 at page 6637, when he said —

> So I am going to kill myself! Why bother doing that? They could go to their garden shed and swallow some weedkiller; it would still do the same thing. Why would they go through the artifice of hacking in to get a potion that they could get from their garden shed and swallow any day? Unfortunately, people take their own lives. The son of a dear friend of mine took his own life two weeks ago. No injuries, waiting for toxicology; somewhere in the house they can access something and manage to take their own life. Why would they go through this artifice of hacking in, tricking and all of that, just to get something that is going to kill them?

I ask members to support this amendment. We need to be very clear that this is a poison that, when taken orally or intravenously, will cause the person's death. This amendment would ensure consistency with the Medicines and Poisons Act 2014, in contrast with the remarks made by the Minister for Health in the other place.

Hon STEPHEN DAWSON: I indicate that the government does not support these amendments. Earlier, the honourable member indicated that a member could leave amendments on the supplementary notice paper to come back to. If a change were to be made in the future at a later clause, we could go back to that amendment—resubmit—and come back to an earlier clause. If this clause goes down, is it the member's intention to leave those other clauses on the supplementary notice paper?

Hon NICK GOIRAN: That is a fair question by the minister. If the amendment were unsuccessful, my intention would be that we would not address this issue again, with the exception of one provision that goes back to the very first question I asked the minister in clause 1; there is perhaps a difference of opinion about whether an issue is typographical or not. Apart from that, no, it would not be my intention to proceed with the rest of them; however, if my amendment were, by some miracle, successful, it would be my intention to move for the other amendments to be passed en bloc.

Hon STEPHEN DAWSON: I thank the honourable member for that. As I was saying, we do not support these amendments. Clause 7 of the bill defines a voluntary assisted dying substance to mean a schedule 4 or schedule 8 poison approved by the CEO for the purpose of causing a person's death. It is clear that a VAD substance is a poison by reference to clause 7. There is no smokescreen; it is consistent with the Victorian act in that regard.

"Prescribed substance" is defined under clause 5 of the bill to mean a voluntary assisted dying substance, generally, prescribed for a patient by the patient's coordinating practitioner; and, in relation to a particular patient, the voluntary assisted dying substance specifically prescribed for the patient by the patient's coordinating practitioner. The Victorian legislation gave some guidance in how it named its voluntary assisted dying substance, but it was not the sole basis for why this terminology is being used in the bill; it was the starting point. Members will note also that the Western Australian legislation is more specific. Once a VAD substance is prescribed to a particular patient, it is called the "prescribed substance".

Under section 3 of the Medicines and Poisons Act 2014, a "substance" includes a compound, preparation, mixture or plant. In the context of the Medicines and Poisons Act and the national Poisons Standard, it is appropriate to use consistent language in this bill. Although a voluntary assisted dying substance will contain a schedule 4 or 8 poison, it may also contain other substances that are used to make it more palatable or able to be administered. Although the inclusion of these substances will not affect the classification of the schedule 4 or 8 poison, it is appropriate to call the entire product a voluntary assisted dying substance or prescribed substance. Furthermore, the word "poison" does, indeed, have a negative connotation. We do not say when we take a Panadol or cough medicine that we are taking a schedule 2 poison; nor do doctors say, when prescribing morphine, methadone or other schedule 8 drugs, that they are giving their patient poison. Using the terms "voluntary assisted dying substance" or "prescribed substance" I think reflects good naming convention. Lastly, the nomenclature of

a voluntary assisted dying substance or prescribed substance reflects naming that is respectful of the patient and the entire voluntary assisted dying process. With those words, I indicate again that the government is not supportive of Hon Nick Goiran's amendment.

Hon NICK GOIRAN: To be clear, I heard at the beginning of the minister's remarks that the government concedes that a voluntary assisted dying substance is a poison.

Hon STEPHEN DAWSON: That has never been in doubt, honourable member.

Hon NICK GOIRAN: The minister can perhaps understand my bemusement. If the government concedes that it is a poison, why would it object to it being called a poison in this bill? The minister has given his reasons, but perhaps he can understand and respect my position.

Hon AARON STONEHOUSE: I have a lot of sympathy for this amendment, given the arguments made by Hon Nick Goiran and the common understanding and definition of the word "poison". It certainly seems to be a more accurate description of what we are dealing with here than "voluntary assisted dying substance". It is at least consistent with the Medicines and Poisons Act and regulations in Western Australia, and it seems to address a concern I have had with this legislation. Although I am in support of the right of individuals to make choices about their own body, as I stated earlier this evening, I am concerned about what seems to be an attempt to sanitise or sterilise the way we deal with voluntary assisted dying—to dress it up and make it sound a little prettier than it really is. Ultimately, what we are dealing with here is someone taking a poison to kill themselves. It is suicide, under the most basic understanding of that word; it is somebody taking their own life and, in this case, using a poison to do so. It may be a compound or substance that is mixed with other things that are not necessarily poison, but certainly a poison is involved. The definition of a poison is a substance you take to end a life. I understand that there are negative connotations around some of these words—poison and suicide—and that they may be upsetting to some people, but we should not water down what will eventually become statute because certain people are sensitive to certain words. Words have meaning, and when we are dealing with statutes, we should use the commonly understood meaning of those words. We should not compromise on language to tiptoe around the sensibilities of certain members of the public. It is, in fact, a poison, and that is the clearest way to understand what we are dealing with, regardless of how offensive that term might be to some people. I am sure that we will deal with this topic again when we start to discuss whether suicide is recorded on a death certificate. In fact, we dealt with this topic in another unrelated piece of legislation when we looked at the Human Reproductive Technology and Surrogacy Legislation Amendment Bill. That legislation tried to insert what I thought was an element of almost social engineering, namely the new made-up term "social infertility". I had never heard of that before, but a biological man who does not have female reproductive organs and therefore cannot give birth to their own child is now described as socially infertile. It is an act of wordsmithing and manipulation of language —

Hon Simon O'Brien interjected.

Hon AARON STONEHOUSE: Yes, it is true. It was in that piece of legislation, honourable member—social infertility. Someone who is incapable of giving birth to their own child because of their lack of female reproductive organs, or perhaps their inability to attract a mate, is socially infertile, as opposed to medical infertility that might otherwise be promoted.

I am getting off the topic. I have a concern about an attempt by perhaps some activist members of the community to push and to change the meaning of commonly understood words to protect people from being offended. I think that is a dangerous route to go down. I think we should stick with language that is commonly understood and that best describes what we are dealing with in these terms, if for little else than to provide clarity in statutory interpretation, at the very least. For that reason alone, I will be supporting the amendment moved by Hon Nick Goiran.

Hon MARTIN PRITCHARD: I rise to indicate that I will not be supporting the amendment. I think it is well dealt with under the definitions clause, and also at clause 7(2), which states —

> A poison approved under subsection (1) is a ***voluntary assisted dying substance***.

I do not think there can be any confusion. I think that language is important. I do not think we necessarily need to show the ugly side of every bit of legislation, so long as it can be well understood.

Hon NICK GOIRAN: I have just one more question of the minister. I accept that in the scheme of everything that we are dealing with in this legislation, this is not the most significant of matters, but nevertheless I wanted to correct the record for what I believe to be the incorrect advice that the minister gave the other place about consistency with the Medicines and Poisons Act, and perhaps we can agree to disagree on that. I am gratified that a concession has been made tonight to acknowledge that the substance is a poison. I hasten to add that the minister did indicate that that was never in doubt.

The minister would be familiar that when people take a poison home with them, sometimes a poisons symbol or emblem is found on the poison. Will that be the case in this instance? It has now been described as a substance, but it is actually a poison. Will the poisons symbol be on it? The minister will remember that under this legislation, we are allowing people to take this substance, which is a poison, home with them. There will not be any locked box. There is no requirement for storage and so on. We know that from the debate in the other place. There are no amendments to that effect. Will there be any requirement for that symbol to be on there?

Hon STEPHEN DAWSON: Clause 72 sets out the requirements.

Hon NICK GOIRAN: It may well say that in clause 72, but will the symbol be on there or not?

Hon STEPHEN DAWSON: That question is probably better asked at clause 72, and my advisers will be able to confirm that information by then.

Hon NICK GOIRAN: With respect, minister, some members might be inclined to support this amendment on the basis of whether the poisons symbol will appear on the substance. Waiting until we get to clause 72 is not going to help us. I note that it says there that, in addition to any labelling requirements under the Medicines and Poisons Act, clause 72 will tell us about other things. Clause 72 will not tell us about this issue. The only place where we are going to know that is under the Medicines and Poisons Act. I guess my question is: will the voluntary assisted dying substance need to have that poisons emblem or symbol on it as a result of the Medicines and Poisons Act 2014?

Hon STEPHEN DAWSON: I cannot tell the honourable member that now. My advisers have undertaken to seek out that information. If the member wants it before we reach clause 72, this evening or tomorrow, I am happy to help the member and provide it, but I give an undertaking that we will have an answer to that question when we get to clause 72.

Hon NICK GOIRAN: One final question to the minister: I take it that, irrespective of the advice that he gets back on that, the position of the government will still be to oppose the amendment.

Hon STEPHEN DAWSON: That is correct.

Division

Amendment put and a division taken, the Deputy Chair (Hon Adele Farina) casting her vote with the noes, with the following result —

Ayes (6)

Hon Jim Chown	Hon Simon O'Brien	Hon Aaron Stonehouse
Hon Nick Goiran	Hon Charles Smith	Hon Ken Baston *(Teller)*

Noes (26)

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

Amendment thus negatived.

Hon NICK GOIRAN: I do not propose at this time to move the amendment standing in my name at 127/5. It is my intention, for the benefit of the hardworking clerks of the chamber, that this amendment remain on the supplementary notice paper in the event that at a later stage the bill is recommitted for consideration of clause 5. By way of explanation, this particular amendment is effectively a consequential amendment to a more substantive one that I have under clause 11. If you like, this is a consequential amendment, as is another one under clause 5, which I will refer to later, and the primary amendment is under clause 11. This is something that an experienced parliamentarian like the Premier would know full well, but he continues to mislead the public. Nevertheless, to facilitate progress I do not propose to move that amendment at this time. Should I need to move the amendment at a later stage, I will. Although I do have other amendments under my name on clause 5, I note that other members have amendments in sequence, so I will leave it to them to make their remarks.

Hon RICK MAZZA: Hon Nick Goiran pointed out that there are a number of consequential amendments. In fact, I have some 46 amendments on the supplementary notice paper, but only around five or six of them are actually substantive amendments; the rest are consequential amendments. It would be somewhat of a nonsense

to move those amendments at this point, not knowing whether the substantive amendments will pass. I have also consulted with the clerks on this issue and I prefer not to move those amendments now. I will move the substantive amendments when we get to those clauses, and if I have some success on those, we can always recommit the bill.

Hon CHARLES SMITH: I will take the advice of the clerks in this instance, as my initial amendments are consequential in nature. I will probably start to move amendments when we get to clause 8.

Hon NICK GOIRAN: The next amendment standing in my name on the supplementary notice paper is at 131/5. It is a consequential amendment to proposed amendments 63/25, 64/25, 67/36 and 68/36. In other words, they are consequential amendments to do with more substantive amendments I have under clauses 25 and 36. For those reasons, I think that it is appropriate that this amendment also be carried over at this time.

Hon MARTIN ALDRIDGE: Just to spice things up a little, I will move the amendment that stands in my name on the supplementary notice paper at 409/5. I remind members that the chamber agreed to my amendment at 408/4 of the supplementary notice paper to insert a new principle—that is, clause 4(1)(ha). This amendment is one of two consequential amendments that will include a definition in the bill of "metropolitan region". I do not think I need to say much more than to move —

Page 6, after line 6 — To insert —

metropolitan region has the meaning given in the *Planning and Development Act 2005* section 4(1);

Hon STEPHEN DAWSON: I indicate that the government supports this amendment for the same reasons that I gave when Hon Martin Aldridge moved his amendment in clause 4 in relation to "principles". There was the clause 4 amendment and there is this one in relation to the definition of a "metropolitan resident" and a further one in relation to the definition of "regional resident". The government is supportive of these three amendments for the reasons I gave earlier.

Hon NICK GOIRAN: I indicate that I will be supporting the amendment, notwithstanding the fact that I was not supportive of the amendment moved by the honourable member to insert a new principle, paragraph (ha), in clause 4(1) because the chamber decided to not incorporate "palliative care" as an issue that regional residents should have equitable access to. Notwithstanding that, I agree with the honourable member that to not do so would make this particular provision otherwise nonsensical. It is important to point out for the benefit of those who will have responsibility to consider the principles in clause 4, if they have duties and powers under the act, including the tribunal and the Court of Appeal and the like, that they will need to know what is meant by "metropolitan region". I congratulate Hon Martin Aldridge for putting forward this amendment.

Amendment put and passed.

Hon CHARLES SMITH: I indicated earlier that there are consequential amendments under my name on the supplementary notice paper that I will deal with under further clauses.

The DEPUTY CHAIR: By way of clarification, honourable member, you will not be moving all the proposed amendments standing in your name in relation to clause 5; is that correct?

Hon CHARLES SMITH: That is correct.

Hon AARON STONEHOUSE: I have a question about the definition of "patient" in clause 5. At line 11 on page 6, it states —

patient means a person who makes a request for access to voluntary assisted dying under this Act;

I have some questions about how that will interact with division 2 in part 3 of the bill and the obligation on a medical practitioner to report a request made to them for voluntary assisted dying and, in fact, their obligation to provide a patient with information that is referred to in clause 4(1)(b). I will leave my questions around the steps that a practitioner must take under division 2 until the chamber considers the clauses under that division. I wonder whether the minister can provide a little bit of information about where the definition for "patient" comes from and why it is defined in these terms. When we get to division 2 in part 3, the language changes a little and rather than a "patient" making a request, it refers to a "person" making a request. The distinction between a patient of a medical practitioner and a person merely making a request gets a little confusing. I ask this because I am a little concerned that, for instance, a medical practitioner could be, I do not know, at a function or out at dinner and a random person could approach them and ask them for information about voluntary assisted dying. That may trigger the obligations for a medical practitioner under division 2, based on the language used in division 2 where it merely refers to a person. Even the definition here of a patient does not require that a patient, as defined in clause 5, needs to be anyone with any kind of therapeutic relationship with a medical practitioner. Again, by my casual reading, it could be any person who approaches a medical practitioner and requests information about voluntary assisted dying. A patient might approach a pathologist who might be merely handling one aspect of someone's therapeutic

care and the patient could ask them questions about voluntary assisted dying. However, they would be in no way qualified to answer the patient and all of a sudden, obligations under division 2 would be triggered. Without getting perhaps too much into the process under division 2, maybe the minister can give us a little information about the definition of "patient" in clause 5 and how that was determined during the consultation and the drafting of this bill.

Hon STEPHEN DAWSON: The language changes because a person may not be a patient of the practitioner until their first request is accepted.

Hon NICK GOIRAN: The next amendment that stands in my name is at 57/5, which seeks to insert a definition for "palliative care and treatment". I note that there is also a proposed amendment by the minister to do a similar thing. Before I move it, I note the advice I received from the clerks earlier that we cannot go back to other parts of the same clause, which I still find a very interesting notion, I have to say. I want to give members a fair opportunity to appreciate that the amendment I will move now will take us to page 6, after line 10. Perhaps we can have a dialogue about the two amendments. I am pleased to see that the government has indicated some appetite for a definition of "palliative care and treatment". It is probably just a question of what that definition should be.

The DEPUTY CHAIR (Hon Adele Farina): Before you do that, does any member want to speak to any part of clause 5 that comes up before page 6, line 10? Once this amendment is moved, that opportunity will be lost.

Hon MARTIN ALDRIDGE: Can I just clarify that the limitation on going backwards is that we are allowed to canvass and converse with the minister and other members about earlier aspects of the clause, but we will be limited in moving new amendments prior to the amendment moved?

The DEPUTY CHAIR: Your clarification is correct.

Hon NICK GOIRAN: I move —

> Page 6, after line 10 — To insert —
>
> > ***palliative care and treatment*** includes a medical, surgical or nursing procedure or other treatment or service that is provided to a person, who has been diagnosed with at least 1 disease, illness or medical condition that is life-limiting, for the purpose of preventing or relieving suffering by means of early identification, assessment and treatment of pain or discomfort, including physical, psychosocial and spiritual distress;

This amendment seeks to provide a broad and inclusive definition of "palliative care" for the purposes of interpreting the Voluntary Assisted Dying Bill 2019. As the bill stands, no definition is provided for the term "palliative care and treatment". I note that this was also a point of discussion when the committee was considering clause 1. This is despite the fact that the term "palliative care and treatment" is found in clause 4(1)(c) and (d) and clause 26(1)(c), and even the reference to clause 26(1)(c) is found in clause 37(1).

I note, in passing, that the term "palliative health care" is included in clause 170, but it relates to a consequential amendment to the Health and Disability Services (Complaints) Act 1995, and this amendment to include a definition of "palliative care and treatment" is not directly relevant to that clause.

The wording of the definition that I have moved builds on the amendment moved by the member for Girrawheen, Margaret Quirk, MLA, in the other place, who sought to insert the following definition. It reads —

> ***palliative care and treatment*** includes a medical, surgical or nursing procedure or other treatment or service that is directed at identifying or relieving the pain, discomfort or distress of a person who has been diagnosed with at least 1 disease, illness or medical condition that is advanced, progressive and incurable and will cause death;

I note that that amendment moved by my learned friend the member for Girrawheen was voted down in the other place, but I also note that unlike this bill, the Victorian Voluntary Assisted Dying Act 2017 contains a definition of "palliative care". The Victorian act provides —

> ***palliative care*** has the same meaning as in the ***Medical Treatment Planning and Decisions Act 2016***;

We can read in the *Hansard* from the other place that the member for Girrawheen had originally intended to move an amendment to insert a similar definition into the bill that is before us that palliative care has the same meaning as found in section 3 of the Guardianship and Administration Act. However, as I read the *Hansard* from the other place, the member for Girrawheen noted that the Minister for Health indicated that this definition was too narrow and outmoded—"outmoded" was the word the minister used, according to the member for Girrawheen on 4 September 2019 at page 6402.

The health minister acknowledged in the other place that the definition of "palliative care" in section 3 of the Guardianship and Administration Act is considered a rather constricted and outdated perspective of what palliative care means. He stated —

> Palliative care in the broader sense is now a much longer, more holistic treatment process and, from that perspective, —

He was referring to the Guardianship and Administration Act definition —

> … it would jar with some of the hospice work and broader work done in the palliative care field.

That was taken from the *Hansard* of the other place on 3 September this year, at page 6339. As it happens, I agree with the health minister's comments. Consequently, the definition that I propose to insert in clause 5 builds on the amendment moved in the other place by the member for Girrawheen and incorporates the definition of "palliative care" accepted by the World Health Organization. The definition that I move to be inserted into clause 5 reflects the longer and more holistic treatment process to which the health minister in the other place referred.

As I understand it, what transpired in the other place was that Minister Cook opposed the member for Girrawheen's amendment to include a definition of the term "palliative care and treatment" in clause 5 because the contemporary common meaning would apply and in the context of the bill the term "palliative care" is used in three provisions in which it does not need defining. On 4 September this year, the Minister for Health told the other place and the member for Girrawheen that there was no need to insert a definition of "palliative care"; "it does not need defining". Consequently, perhaps the minister in this place can understand my bemusement that there is an amendment standing in his name, notwithstanding the comments made by the minister in the other place.

I pause at this point to indicate that it makes it difficult for the progress of the legislation in this place when we are trying to rely on the advice of the health minister, who has the carriage of the bill in the other place, only to find that consistently incorrect information was provided to the other place.

It makes it very difficult for us to make efficient progress when that is the standard of competence displayed by the minister in the other place. Nevertheless, I suggest that a definition of "palliative care and treatment" is needed for those clauses in the bill in which the term is used. As I indicated earlier, palliative care and treatment is included in the very important clause 4 principles, specifically at subclause (1)(c) and (d), which, as we learnt earlier when considering clause 4, must be considered by the State Administrative Tribunal and can also be a ground for appeal to the Court of Appeal. In addition, coordinating and consulting practitioners are required to inform patients of the palliative care and treatment options available to them and the likely outcomes of that care and treatment, which can be found in clauses 26 and 37. In order for patients to be provided with the best care available and to support the principle of informed consent, it is appropriate that patients be informed of the palliative care and treatment options available to them in the broadest sense of the term. If we are asking medical practitioners to do this and they have a duty to do it, we have a responsibility to define that for them.

Of course, we know from the so-called "My Life, My Choice" report that the Joint Select Committee on End of Life Choices heard considerable evidence to suggest that a lack of understanding in the community, and even in the medical profession, is creating a barrier between patients and the palliative care available to them. Several factors contribute to a general confusion and apprehension about palliative care. I refer to page 74 of the majority report, and in particular paragraph 3.82, where the committee listed the following factors —

- avoiding discussions about death;
- not fully understanding what palliative care means and recognising when it should begin; and
- not knowing how to access and navigate palliative care services.

The committee states on page 75 of the report, at paragraph 3.87 —

> … there continues to be a misconception that palliative care is only for cancer patients in the last days or weeks of life.

The committee went on to say at paragraph 3.88 —

> A comprehensive study using data from 2009 and 2010 starkly illustrates that palliative care services remain overwhelmingly accessed by patients suffering from cancer.

And at paragraph 3.89 —

> The study reveals that more can be done to promote understanding of palliative care in the community and with health professionals. It also reveals that health professionals may not be actively referring non-cancer patients into palliative care.

The committee went on to say at paragraph 3.95 —

> The committee received evidence from a witness whose experience with Western Australia's health care system demonstrated the difficulty of gaining access to palliative care services …

The report states at paragraph 3.96 —

> Despite previous experiences with cancer and multiple life-limiting conditions, the health professionals had never had an honest conversation about the dying process with Ms Calcutt or her partner. The referral to palliative care services only came at the insistence of their family friend. Anecdotally this demonstrates the committee's concern that health professionals, even specialists, may not recognise the need for palliative care or may not know how to refer their patients into the service.

The committee further stated at paragraph 3.149 —

> Unfortunately, there are many barriers to the provision of effective palliative care in Western Australia, not least of which being the apparent lack of a consistent understanding of palliative care within the community and among health professionals.

In contrast to these statements found in the "My Life, My Choice" report is a statement at page 6410 of *Hansard* made by the Minister for Health. In response to Dr David Honey, the member for Cottesloe, the minister stated on 4 September 2019 —

> I certainly do not accept his premise that there is a problem with palliative care in Western Australia and I reference our record investment in it.

It is interesting that there always seems to be this defensive attitude when it comes to palliative care. No-one is not acknowledging the investment that has been made by the government, but that does not mean that health professionals fully understand palliative care.

The CHAIR: Hon Nick Goiran.

Hon NICK GOIRAN: The debate in the other place between the health minister and the shadow health minister on this point included the following exchange. The member for Dawesville said —

> … if a definition of palliative care already exists at law, especially in something like the Guardianship and Administration Act, which provides the right and ability for someone to act on someone's behalf due to incapacity, why would we not seek to prescribe that for information that should be provided to somebody if and when they need to access palliative care information that is required under clause 26 and thus, I think, warrants definition?

The response from the health minister was —

> This is not a tick-a-box exercise. This is really providing some context for the conversation and the decisions that a medical practitioner would make. In that sense, it is not necessary for us to define palliative care to work out whether the patient in question has had opportunities to discuss palliative care plus one, and therefore meets a particular threshold. This is about the therapeutic relationship between the practitioner and the patient. There would also be conversations, potentially, with that patient's palliative care specialist in that context. I do not want to create the impression that somehow there is some threshold over which a patient must pass in order to have been considered familiar with the concept of palliative care and other treatments that might be available. It is simply directing the medical practitioner to make some observations and have some conversations to satisfy themselves that the patient in this particular case is aware of the range of opportunities available to them.

The member for Dawesville then said —

> Does the minister think there is a risk at all, in not defining it, that there could possibly be a lower level of information provided to a patient? As the minister would appreciate, a number of elements are prescribed in this legislation—professional care services is one. If we provide a prescription in these definitions for what that looks like, we can at least ensure there is a minimum mandatory requirement to provide information … Does the minister think that a lack of prescription poses any risk at all? Is the minister absolutely comfortable with that? As someone who supports the legislation, can the minister provide me comfort that without the insertion of that definition, there will always be at a minimum a high level of information provided to a patient by a medical practitioner?

The health minister said —

> I can give the member that assurance.

The minister gave assurance to the member for Dawesville in the other place to keep him quiet, to suppress his voice in the debate, only for us to come into this place and now have a definition provided by the minister. It shows such disrespect to the members of the other place. I feel for those members who had to sit through a debate, including until five o'clock in the morning, to be told that kind of information from the health minister only for them now to find that they were right. Dr Honey was right, Mr Kirkup was right and the member for Girrawheen was right. In the health minister's response to the member for Dawesville he works from the assumption that the patient will already have a palliative care specialist, yet we know from the inquiry, the so-called "My Life, My Choice" report, that most Western Australians who would benefit from the care and expertise of a palliative care specialist do not

have access to those specialist services. As I mentioned earlier, that report from the committee clearly indicates that health professionals, including specialists, do not recognise the need for palliative care or may not know how to refer their patients into the service. This says nothing of how the same health professionals can then be expected, under the current bill, to inform patients requesting voluntary assisted dying of—to effectively quote clauses 26 and 37—the palliative care and treatment options available to them and the likely outcomes of that care and treatment.

A broad, inclusive and holistic definition of "palliative care", as proposed by me in this amendment to clause 5, will assist persons exercising a power or performing a function under the bill, including coordinating and consulting practitioners, in their provision of information on palliative care and treatment options by directing those persons to the most broad, encompassing and modern understanding of palliative care; the understanding that the Joint Select Committee on End of Life Choices identified as clearly lacking in both the community and health professionals in our state. It is all very good for the health minister to assure members in the other place that at a minimum a high level of information will be provided to a patient by a medical practitioner, but this amendment to include a broad, inclusive and holistic definition of "palliative care" serves only to support the minister's assurance in the other place to the member for Dawesville, as ambitious as I think that assurance was. I conclude by seeking the support of members for the amendment to include a definition of "palliative care and treatment", whether that be the one that I have proposed or, depending on debate, the one that is proposed by the minister. I draw to their attention that there was support for this amendment in the other place, including from the member for Churchlands, who said —

> I think it is pretty important that we help the community, and the media who report on these things, to understand how we as a Parliament are framing what palliative care means.

He said that on 4 September this year, as stated on page 6405 of *Hansard*. The Leader of the Opposition, the member for Scarborough, said on 4 September this year, at page 6407 —

> Including this definition —

She was referring to the definition moved by the member for Girrawheen —

> would increase the significance and prominence of our focus on palliative care going forward.

For those reasons, I seek the support of members for the inclusion of a definition of "palliative care and treatment".

Hon STEPHEN DAWSON: The government's position on this issue has evolved. We now seek to insert a definition of "palliative care" to assist with the interpretation and operation of the bill. Those who have a responsibility under the act will have clarity around what constitutes palliative care. We are amenable to change if it is used as good practice. This is such a case.

We will not introduce the definition due to a fear of a lower standard being otherwise attained. We will include the definition to provide clarity on the contemporary meaning of palliative care. The government's commitment to palliative care is not only demonstrated by the inclusion of the palliative care definition in this bill; it is also demonstrated by its acceptance of all recommendations of the joint select committee, including recommendation 10, which reflects the findings mentioned by Hon Nick Goiran in his contribution this evening.

The government is not supportive of Hon Nick Goiran's amendment as it stands. His amendment provides examples of palliative care treatment that includes psychosocial and spiritual distress. As he pointed out, these words are used in the policy statement of the World Health Organization when discussing an approach to palliative care. However, I am advised that directly using words from a policy statement does not necessarily translate into good legislation.

The amendment that I have on the supplementary notice paper seeks to include a definition of "palliative care and treatment" in the bill. I am advised that this definition reflects best practice palliative care as understood in Western Australia and is consistent with the policy intent stated by Palliative Care WA and the World Health Organization. The definition also reflects terminology such as "life-limiting", which is well accepted in palliative care and in health care more broadly and reflected in the department's "WA End-of-Life and Palliative Care Strategy 2018–2028" and the Australian Medical Association's code of ethics. They are the reasons that we are not supportive of Hon Nick Goiran's wording, albeit we support the inclusion of a definition of "palliative care and treatment" in the bill.

Mr Chairman, I seek your guidance. Given that the question before us is that the words to be inserted be inserted, and the amendment is in Hon Nick Goiran's name, if the government is not supportive of that amendment but we have our own, is the way for us to deal with it to vote down Hon Nick Goiran's amendment and then move the amendment standing in my name?

The CHAIR: That is probably the most straightforward way of doing it. If Hon Nick Goiran wanted to seek leave to withdraw his motion, that is another way of doing it. In the absence of anyone seeking to do that, I will simply proceed with putting the question after we have heard from Hon Nick Goiran.

Hon NICK GOIRAN: At the end of the day, as I indicated earlier, the spirit and the genesis of my amendment is the work undertaken by the member for Girrawheen, who is my co-chair of the Parliamentary Friends of Palliative Care. I recognise her longstanding commitment to and passion for the area of palliative care in Western Australia and her significant contribution to it. I found it very disrespectful that that member's amendment was just dismissed out of hand by the government in the other place. The minister heard my remarks earlier tonight and the remarks by the health minister that there was no need for a definition. That was the spirit and the genesis of me moving this forward. I do not have any great desire for or ownership of the form of words; I am even amenable to potentially seeking leave to withdraw my amendment so that we can support the minister's amendment. To facilitate that process, and to provide me some comfort about the form of words that the minister is proposing, perhaps he could indicate who was consulted on the drafting of that particular definition.

The CHAIR: We are back to the question that the words proposed to be inserted be inserted.

Hon STEPHEN DAWSON: The consultation had already been done on the "WA End-of-Life and Palliative Care Strategy 2018–2028", but in terms of who was involved in conversations on this issue, certainly the palliative care unit in the Department of Health was consulted on this issue, along with the end-of-life choices team. They were both consulted on the wording that is before us at the moment.

Hon NICK GOIRAN: I have one final question on that. Was Palliative Care Western Australia consulted; and, if so, what was its response to this definition?

Hon STEPHEN DAWSON: No, it was not specifically consulted in landing on the words before us now, but it was consulted on the strategy that I referred to earlier. I am advised that the advisers looked at its policy documentation and that was taken into consideration in the words that we have landed on tonight.

Hon NICK GOIRAN: In light of those remarks, I seek leave to withdraw my amendment. I foreshadow for members that the rationale behind that is that I will seek to support amendment 457/5 standing in the name of the minister on the basis that the genesis of it was the work done by the member for Girrawheen.

The CHAIR: Please resume your seat, Hon Michael Mischin. We have to take these things in order. The member has sought leave to withdraw his amendment, so we have to deal with that question now. Is leave granted?

Hon Michael Mischin: That was the reason I rose, Mr Chair.

Leave denied.

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

Point of Order

Hon STEPHEN DAWSON: Mr Chair, it is getting late in the evening, so I seek your guidance. If a majority of people in the chamber indicated that—the Deputy Clerk has advised me that it is if there is no dissentient voice, so I think I will sit down.

The CHAIR: I am going to knock off, because I am redundant if that is the case! Clearly, leave was not being granted because at least one member did not want to proceed down that way. Therefore, we will not proceed down that way at this time at least.

Committee Resumed

Hon MICHAEL MISCHIN: I am sorry to have caused a complication. I was hoping to be able to determine whether I would be able to support Hon Nick Goiran's application for leave by clarifying something about the two alternatives that we are being presented with. Ordinarily, I would not interfere in his exercise of his judgement in this, but there are features of the two definitions that are common, but there are also significant differences. I am a little troubled that the definition that has been proposed by the government is rather more limited than the one that Hon Nick Goiran has proposed. He has said that that it drew on a World Health Organization description. The minister has said that sometimes policy statements may not be easily translated into legislation and I accept that entirely. However, Hon Nick Goiran's definition is an inclusive definition and very broad. The definition proposed by the government in amendment 457/5 is a limited definition. It is very broad, but rather than being an inclusive one, it "means" certain things.

I would like to know, in order to make up my mind up as to whether I support Hon Nick Goiran's proposed amendment or the government's, what the material differences are, as the government sees them, that makes their definition preferable to the broader one that has been proposed. There are some obvious differences. One is that the government's proposed amendment mentions a "progressive and life-limiting" disease, illness or medical condition. Why "progressive", for example? What is material about that as opposed to a life-limiting medical condition, disease or illness? Why is it that elements such as "physical, psychosocial and spiritual distress" are being abandoned in place of the vague "quality of life" concept? Quality of life according to whom? We heard earlier under the

principles in clause 4 that quality of life is meant to be determined subjectively. How does that fit with something that is an objective exercise of palliative care and treatment—meaning that it is directed towards improving comfort and quality of life in the manner that is proposed in the government definition? What does "quality of life" mean for the purposes of being able to decide that?

I would like to know more about, particularly, the minister's comment that this is a definition of "palliative care and treatment" as understood in Western Australia. By whom is it understood? We have not had any consultation other than within government. We do not know whether this particular definition is drawn from any other definition that is used anywhere else. I would like to know more about its genesis, how it was formulated and against which touchstones, particularly when one sees the attitude of the government in the other place. The minister has simply dismissed it by saying that the government's position has evolved. It has "changed", I presume. If it has evolved, why has it? It was found to be unnecessary in the other place by the Minister for Health, whose bill this is. It was dismissed out of hand when people were talking about it down there. Now, all of a sudden, the government comes up with its own definition and says that its position has evolved. What has caused it to evolve? What are we dealing with here, and why has the government proposed this particular amendment in these words?

Hon Sue Ellery interjected.

Hon MICHAEL MISCHIN: The Leader of the House has some contribution to make; I would be interested to hear it.

Hon Stephen Dawson: She can seek the call.

The CHAIR: If she wants the call, she can ask for it. Minister.

Hon STEPHEN DAWSON: Honourable member, I do not propose to go over the points that I made earlier. Our position has evolved.

Hon Michael Mischin: Why?

Hon STEPHEN DAWSON: It has evolved based on consideration of the debate that has happened and the views raised by members, and consideration with a range of stakeholders. Our position has evolved and, as I have outlined, we now seek to include a definition in the bill to assist in its interpretation and operation. I do not propose to spend weeks on it. With the greatest of respect, I am not an apologist for anybody at the far end of the building; certainly, that place operates very differently from how we operate here. I am dealing with the bill before us here, and it is my intention to continue to engage in a meaningful and respectful way with the honourable members in this chamber. That is certainly how I operate. I think the bill before us warrants that respect.

On the differences, I guess things like psychosocial and spiritual distress are subjective issues. Hon Nick Goiran's proposed amendment refers to "medical, surgical or nursing procedure or other treatment". Our proposed amendment is wider. It states —

> is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering …

"Care and treatment" is meant to be broader than "medical, surgical or nursing procedure or other treatment". Our proposed amendment is broader. There is no trick or anything else going on here. We honestly believe that the amendment proposed in my name is better and broader than the one proposed by Hon Nick Goiran, which he has indicated he will seek leave to withdraw. I will say it again: the definition is included here to assist in the interpretation and operation of the bill and to assist those who have responsibility under the act to have clarity on what constitutes palliative care.

Hon NICK GOIRAN: Again, I foreshadow that I will seek leave to withdraw my amendment. I appreciate the helpful observations made by my colleague. I agree with him entirely. I want to make it clear: I am not seeking leave to withdraw because I think that my definition is more restrictive than the government's proposed amendment; on a plain reading of it, that cannot be right. I am just accepting that we want to make progress. The government has considered this matter. The member for Girrawheen deserves all credit for first raising this. I again acknowledge that she was treated in a shabby fashion by the minister in the other place. I am pleased that there will now be an amendment, which should have happened in the first instance.

With those remarks, Mr Chairman, I seek leave to withdraw my amendment.

Amendment, by leave, withdrawn.

Hon STEPHEN DAWSON: I move —

> Page 6, after line 10 — To insert —
>
> ***palliative care and treatment*** means care and treatment that —

(a) is provided to a person who is diagnosed with a disease, illness or medical condition that is progressive and life-limiting; and

(b) is directed at preventing, identifying, assessing, relieving or treating the person's pain, discomfort or suffering in order to improve their comfort and quality of life;

Hon AARON STONEHOUSE: I rise to indicate that I support the amendment moved by the minister. I thank him for it. I might just quickly take this opportunity to put on the record my concern that it does appear to be a far more limited definition. I would have spoken to that earlier, but I did not want to get in the way of the member seeking leave. The definition from the World Health Organization that was put forward by Hon Nick Goiran, which has not been agreed to by the chamber, made specific reference to psychosocial and spiritual distress. From what I have learnt about palliative care in the last few months, that seems to be a very important aspect of palliative care, especially in Western Australia. "Spiritual" is a vague, flowery kind of term. What does it actually mean in statute? It is hard to define. Perhaps it is best that it is not defined—not too clearly at least. It is better left to be vague. A patient may or may not be a religious person, but when someone is facing the end, there is certainly an aspect of what people might refer to as "spiritual distress". When someone comes to terms with the finality of death and what it means, what their place is in the universe and whether they have religion to help guide them through that process or are relying on something else, it is perhaps best to describe it as a sense of existential dread. I think an aspect of palliative care is treatment or support for that spiritual distress. In that context, "spiritual" can mean whatever a person needs it to mean to address that issue, discomfort and fear that a patient faces towards the end.

I would also like to pick up on something mentioned by Hon Michael Mischin, and that is the use of the word "progressive" in the amendment—a "condition that is progressive and life-limiting". That seems to narrow the scope somewhat in this definition. In the consultation I undertook with palliative care specialists and people who provide palliative care services, they stressed to me the importance of palliative care being provided to patients very early on in their diagnosis and prognosis, and that it is not offered to a patient solely to treat pain in their final weeks or days before they pass. It is something that is provided right at the point of diagnosis of a serious life-threatening illness and it continues. It could continue for years. I wonder whether making reference to a patient who is diagnosed with a disease, illness or medical condition that is progressive could be interpreted as meaning that an illness has progressed somewhat, rather than someone who, at the time of diagnosis, is seeking palliative care and treatment. Maybe I am wrong in that assessment, but it seems to make that implication, at least in the reading of a layperson. Notwithstanding that, it is certainly better to have some definition here rather than none. I am happy to support this amendment, if not with some reservation.

Amendment put and passed.

The CHAIR: The question now is that clause 5, as amended, be agreed to. I turn to the supplementary notice paper, and further to a previous decision of the chamber, unless anyone has any view to the contrary, I intend to not call on amendments 133 to 141. In respect of page 5 of the supplementary notice paper and amendment 27/5, I understand that there is an intention that it remain on the supplementary notice paper for the present, and may be moved at a later stage. If any authors of these amendments want to do something different, stand up and sing out. That is what I propose to do. That brings us to amendment 58/5.

Hon NICK GOIRAN: The amendment standing in my name at 58/5 is an important amendment. It is a consequential amendment to more substantive matters that I have proposed for clauses 35 and 36. This has to do with a referral to a psychiatrist for a further assessment and, indeed, other consequential amendments I have on the supplementary notice paper that would seek mandatory psychiatric assessment. I certainly intend to pursue those amendments at that particular time. For the present moment, it would suit me, for the benefit of the clerks, if the amendment standing in my name at 58/5 could remain on the supplementary notice paper, but I do not propose to move it at this time.

The CHAIR: That amendment will remain on the supplementary notice paper for the present, and in any further issues that are printed. Hon Martin Aldridge, do you intend to move amendment 410/5 at this stage or reserve it as well?

Hon MARTIN ALDRIDGE: This amendment is in a similar vein to the one that I moved earlier in clause 5. It is a consequential amendment to a substantive amendment that was agreed to in clause 4. In order to give full effect to the amendment in clause 4, this amendment now needs to be considered. It is fairly self-explanatory. It defines "regional resident" for the purposes of the clause 4 amendment that I have just referenced. With those few words, I move the amendment standing in my name at 410/5 —

Page 7, after line 20 — To insert —

regional resident means a person who ordinarily resides in an area of Western Australia that is outside the metropolitan region;

Hon STEPHEN DAWSON: I indicate that we are supportive of this amendment, for the reasons that I identified earlier this evening.

Hon NICK GOIRAN: I also support the amendment that is before us, for precisely the same reasons that I supported the amendment moved by Hon Martin Aldridge on the supplementary notice paper at 409/5.

Amendment put and passed.

The CHAIR: The next amendment notified on the SNP is 28/5. I understand that the proposer wishes that to remain on the supplementary notice paper, so we will move on without dealing with it at the present. That brings me to amendment 413/5 standing in the name of Hon Rick Mazza. Hon Rick Mazza, do you wish to move that?

Hon RICK MAZZA: No, Mr Chair. That is also a consequential amendment that I would like to have stay on the supplementary notice paper.

The CHAIR: We will leave that until afterwards. That is noted. That brings us to amendment 142/5, which would fall away. We now come to amendment 143/5 standing in the name of Hon Nick Goiran.

Hon NICK GOIRAN: I move —

> Page 8, lines 7 to 9 — To delete "administration of a voluntary assisted dying substance and includes steps reasonably related to that administration;" and substitute —
>
> > process by which a person is given assistance to die in accordance with this Act, whether by voluntary euthanasia or by assisted suicide;

The CHAIR: The question in the first instance is that the words proposed to be deleted be deleted. I will be interrupting debate very soon to report progress, but for now I give the call to Hon Nick Goiran, if he can be brief.

Hon NICK GOIRAN: I will endeavour to do so, Mr Chairman. This amendment to the definition of "voluntary assisted dying" makes it explicitly clear that this bill provides for a voluntary assisted dying scheme in Western Australia, whereby both assisted suicide, which is self-administration, and voluntary euthanasia, which is practitioner administration, are available to eligible patients. Unlike my previous amendment to change the short title of the bill to remove the term "Voluntary Assisted Dying" from the title of the act, this amendment will retain the term in the title of the act, and in clause 5 of the bill, as well as in the title of the Voluntary Assisted Dying Board established under part 9, but will seek to elucidate exactly what voluntary assisted dying entails, based on longstanding use of the terms "voluntary euthanasia" and "assisted suicide" in the Netherlands, Luxembourg and Belgium, where causing the death of a person by both practitioner administration and self-administration of a poison has long been legally practised and around which different guidelines and procedures are in place.

The CHAIR: With those introductory remarks, I had better interrupt the debate to report progress.

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