VOLUNTARY ASSISTED DYING BILL 2019

Returned

Bill returned from the Council with amendments.

Council's Amendments — Consideration in Detail

The amendments made by the Council were as follows —

No 1

Clause 4, page 3, after line 16 — To insert —

(ha) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan region;

No 2

Clause 4, page 3, line 18 — To delete "abuse;" and substitute —

abuse or coercion;

No 3

Clause 5, page 6, after line 6 — To insert —

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

No 4

Clause 5, 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;

No 5

Clause 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;

No 6

New Clause 9A, page 10, after line 5 — To insert —

9A. Health care worker not to initiate discussion about voluntary assisted dying

(1) In this section —

health care worker means —

(a) a registered health practitioner; or

(b) any other person who provides health services or professional care services.

(2) A health care worker who provides health services or professional care services to a person must not, in the course of providing the services to the person —

(a) initiate discussion with the person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to the person.

(3) Nothing in subsection (2) prevents a medical practitioner or nurse practitioner from doing something referred to in subsection (2)(a) or (b) if, at the time it is done, the medical practitioner or nurse practitioner also informs the person about the following —

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

(4) Nothing in subsection (2) prevents a health care worker from providing information about voluntary assisted dying to a person at the person's request.

(5) A contravention of subsection (2) by a registered health practitioner is unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.

(6) Subsection (5) overrides section 10(1).

(7) A contravention of subsection (2) by a provider, as defined in the *Health and Disability Services (Complaints) Act 1995* section 3(1), is taken to be unreasonable conduct described in section 25(1)(c) of that Act.

No 7

Clause 11, page 10, line 16 — To delete "commit" and substitute —

die by

No 8

Clause 16, page 13, line 19 to page 14, line 2 — To delete the lines and substitute —

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

(a) the medical practitioner —

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

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

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

and

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

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

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

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

No 9

Clause 16, page 14, line 4 — To delete "subsection (2)(a), (b) and (c)" and substitute —

subsection (2)(a)(i), (ii) and (iii)

No 10

Clause 17, page 14, after line 11 — To insert —

(aa) made during a medical consultation; and

No 11

Clause 23, page 17, after line 12 — To insert —

(3) Nothing in this section prevents the coordinating practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

No 12

Clause 25, page 18, after line 8 — To insert —

(5) A registered health practitioner or other person to whom the patient is referred under subsection (2) or (3) must not be —

(a) a family member of the patient; or

(b) a person who knows or believes that they —

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

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

No 13

Clause 26, page 19, line 13 — To delete "or," and substitute —

and,

No 14

Clause 28, page 20, after line 7 — To insert —

(2A) As soon as practicable after completing the first assessment report form, the coordinating practitioner must give a copy of it to the patient.

No 15

Clause 28, page 20, after line 14 — To insert —

(v) whether the patient's first language is a language other than English;

(vi) whether the coordinating practitioner engaged an interpreter in accordance with section 160(2) to communicate the information in section 26 to the patient;

No 16

Clause 28, page 20, line 27 — To delete "referral;" and substitute —

referral (including a copy of any report given by the registered health practitioner or other person to whom the patient was referred);

No 17

Clause 28, page 20, after line 27 — To insert —

(ia) if the patient was assisted by an interpreter when having the first assessment, the name, contact details and accreditation details of the interpreter;

No 18

Clause 28, page 20, after line 27 — To insert —

(ia) the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment;

No 19

Clause 34, page 23, after line 10 — To insert —

(3) For the purposes of subsection (1), the consulting practitioner must independently of the coordinating practitioner form their own opinions on the matters to be decided.

No 20

Clause 34, page 23, after line 10 — To insert —

(4) Nothing in this section prevents the consulting practitioner from having regard to relevant information about the patient that has been prepared by, or at the instigation of, another registered health practitioner.

No 21

Clause 36, page 24, after line 5 — To insert —

(5) A registered health practitioner or other person to whom the patient is referred under subsection (2) or (3) must not be —

(a) a family member of the patient; or

(b) a person who knows or believes that they —

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

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

No 22

Clause 39, page 25, after line 2 — To insert —

(2A) As soon as practicable after completing the consulting assessment report form, the consulting practitioner must give a copy of it to the patient.

No 23

Clause 39, page 25, line 25 — To delete "referral;" and substitute —

referral (including a copy of any report given by the registered health practitioner or other person to whom the patient was referred);

No 24

Clause 39, page 25, after line 25 — To insert —

(ka) if the patient was assisted by an interpreter when having the consulting assessment, the name, contact details and accreditation details of the interpreter;

No 25

Clause 39, page 25, after line 25 — To insert —

(ka) the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment;

No 26

Clause 41, page 26, after line 25 — To insert —

(ia) if the patient was assisted by an interpreter, the name, contact details and accreditation details of the interpreter;

No 27

Clause 41, page 27, line 7 — To delete "declaration." and substitute —

declaration; and

(iii) is not the coordinating practitioner or consulting practitioner for the patient making the declaration.

No 28

Clause 49, page 30, after line 31 — To insert —

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

No 29

Clause 50, page 31, after line 29 — To insert —

(da) if the patient was assisted by an interpreter, the name, contact details and accreditation details of the interpreter;

No 30

Clause 53, page 33, line 17 — To delete "training." and substitute —

training; and

(c) the person is not a family member of the patient; and

(d) the person does not know or believe that they —

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

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

No 31

Clause 55, page 34, line 22 — To insert after "assisted" —

dying

No 32

Clause 56, page 36, after line 12 — To insert —

(ea) if the patient was assisted by an interpreter when revoking the administration decision, the name, contact details and accreditation details of the interpreter;

No 33

Clause 59, page 39, after line 12 — To insert —

(fa) if the patient was assisted by an interpreter when making the administration decision, the name, contact details and accreditation details of the interpreter;

No 34

Clause 60, page 40, lines 9 and 10 — To delete the lines and substitute —

(d) the date, time and location where the prescribed substance was administered;

(da) the date and time of the patient's death;

(db) the period of time that lapsed between the administration of the prescribed substance and the patient's death;

(dc) details of any complications relating to the administration of the prescribed substance;

No 35

Clause 61, page 41, line 5 — To insert after "appeared to be" —

free, voluntary and

No 36

Clause 62, page 41, line 17 — To insert after "unable" —

or unwilling

No 37

Clause 65, page 44, line 3 — To delete "disposer);" and substitute —

disposer and the penalties for offences under that section);

No 38

Clause 65, page 44, after line 3 — To insert —

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

No 39

Clause 65, page 44, line 11 — To delete "patient." and substitute —

patient if —

(a) the patient directs the person to complete the contact person appointment form; and

(b) the person has reached 18 years of age.

No 40

Clause 68, page 45, after line 20 — To insert —

(1A) In this section —

Schedule 4 poison and ***Schedule 8 poison*** have the meanings given in the *Medicines and Poisons Act 2014* section 3.

No 41

Clause 68, page 45, after line 24 — To insert —

(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

No 42

Clause 68, page 46, after line 4 — To insert —

(da) the method by which the substance will be self-administered;

(db) the expected effects of self-administration of the substance;

(dc) the period within which the patient is likely to die after self-administration of the substance;

(dd) the potential risks of self-administration of the substance;

No 43

Clause 68, page 46, after line 14 — To insert —

(aa) the Schedule 4 poison or Schedule 8 poison, or combination of those poisons, constituting the substance;

No 44

Clause 68, page 46, after line 16 — To insert —

(ab) the method by which the substance will be administered;

(ac) the expected effects of administration of the substance;

(ad) the period within which the patient is likely to die after administration of the substance;

(ae) the potential risks of administration of the substance;

No 45

Clause 72, page 49, lines 6 and 7 — To delete "patient to whom it is supplied or their contact person." and substitute —

contact person for the patient to whom it is supplied.

No 46

Clause 96, page 64, after line 23 — To insert —

(da) a former coordinating practitioner or consulting practitioner for the patient if the person is not a party to the proceeding;

No 47

Clause 96, page 64, lines 25 and 26 — To delete "the administering practitioner for the patient." and substitute —

a person to whom the role has been transferred.

No 48

Clause 106, page 70, after line 18 — To insert —

(da) a former coordinating practitioner or consulting practitioner for the patient if the person is not a party to the proceeding;

No 49

Clause 106, page 70, lines 20 and 21 — To delete "the administering practitioner for the patient." and substitute —

a person to whom the role has been transferred.

No 50

Clause 107, page 70, after line 27, the Table the 1st row the 1st column — To delete —

s. 21(1)

No 51

Clause 113, page 74, line 12 — To delete "faith," and substitute —

faith and with reasonable care and skill,

No 52

Clause 151, page 87, after line 12 — To insert —

(ba) participation in the request and assessment process, and access to voluntary assisted dying, by patients who are regional residents;

No 53

Clause 154, page 88, after line 19 — To insert —

(ba) the number of any referrals made by the Board under section 117(c); and

No 54

Clause 154, page 88, after line 27 — To insert —

(f) information about the extent to which regional residents had access to voluntary assisted dying, including statistical information recorded and retained under section 151(1)(ba), and having regard to the access standard under section 154A.

No 55

New Part 9A, page 89, after line 11 — To insert —

Part 9A — Access standard

154A. Standard about access to voluntary assisted dying

(1) The CEO must issue a standard (the ***access standard***) setting out how the State intends to facilitate access to voluntary assisted dying for persons ordinarily resident in Western Australia, including how the State intends to facilitate those persons' access to —

(a) the services of medical practitioners and other persons who carry out functions under this Act; and

(b) prescribed substances; and

(c) information about accessing voluntary assisted dying.

(2) The access standard must specifically set out how the State intends to facilitate access to voluntary assisted dying for regional residents.

(3) The CEO may modify or replace the access standard.

(4) The CEO must publish the access standard on the Department's website.

The SPEAKER: Minister, do you wish to make a statement?

Mr R.H. COOK: I have asked the Clerk whether a marked-up copy of the Voluntary Assisted Dying Bill 2019 incorporating the Council's amendments could be made available for today's debate. A marked-up version is available, but it is an internal working document of the Council and not an official product of the Parliamentary Counsel's Office. The Clerk is happy for this internal working document to be made available on the understanding that no guarantee can be made as to its accuracy. Parliamentary Counsel's Office has made a cursory check of this version of the bill and has identified some minor typographical and formatting errors. With those caveats in mind, members may find this a useful document to have today.

The SPEAKER: Minister, shall we start with amendment 1?

Mr R.H. COOK: I was going to say that I seek leave to move them en bloc, Mr Speaker, but I think it is more appropriate that I move —

That amendment 1 made by the Council be agreed to.

Ms M.M. QUIRK: As I understand it, this amendment, which is to clause 4(1), states —

(ha) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in the metropolitan region;

Firstly, I understand this was moved by Hon Martin Aldridge. So that this *Hansard* will stand alone, for each clause that I am interested in, I am going to ask the minister to indicate who moved the amendment. I think that would be helpful.

Mr R.H. Cook: No problem.

Ms M.M. QUIRK: I see that both the Leader of the Nationals WA and the minister are assenting that this was moved by Mr Aldridge. I also understand that during proceedings upstairs, as well as the entitlement for the same level of access to voluntary assisted dying, an amendment was put up for the same access to be granted for palliative care. I understand that that amendment did not pass. Why was that not agreed to?

Secondly, in a very restricted legal interpretation, express mention of one thing means the exclusion of others. The implication could be that although regional people should have the same level of access to voluntary assisted dying, they will not necessarily get a similar level of access to palliative care.

In the interests of expedition, I will ask all my questions at once. Thirdly, as I understand it, these are merely principles and are not binding, so why are they even there?

Mr R.H. COOK: I thank the member for her question. She is right. This is part of a suite of amendments that were proposed by Hon Martin Aldridge to address concerns he had about regional residents' access to voluntary assisted dying. This amendment was supported by the government. The amendments that he put forward reflect the government's commitment to making voluntary assisted dying accessible to all members of the Western Australian community, both regional and metropolitan. The amendments are also consistent with the government's commitment to enable real end-of-life choices to the Western Australia community, noting that we have already promised a record investment in palliative care and are looking into the accepted recommendations about advance health directives. As I said, a range of amendments were put forward by Hon Martin Aldridge. They were amendments 1, 3 and 5. This first amendment is to the principles of the legislation, including that access to voluntary assisted dying should be available to anyone, regardless of where they live. That is a principle that we all agree with, so we agreed with Hon Martin Aldridge on this issue.

The member for Girrawheen raised palliative care. As the member is aware, palliative care has been a recent focus of the government. Ultimately, this bill is about voluntary assisted dying. It is not about palliative care or end-of-life choices in general. As I have observed, we are already looking into a range of issues relating to palliative care that were raised in the report of the Joint Select Committee on End of Life Choices and are undertaking a considerable amount of work in this area. The member would be familiar with the $59 million pledge the government made this year to improve palliative care services, particularly in the member's area—the north metropolitan area. The member may also be interested to note that the Minister for Environment gave an undertaking in the Legislative Council to the establishment of a joint select committee into palliative care that will oversight a lot of this new spending and provide further focus for the government on where it might move in the future.

We support these amendments because we believe they are important. As the member has said, these are principles, but other amendments later in the bill go to how we will enliven the principles. The principles are an enunciation of our aspirations as a community. We certainly aspire to people's access to voluntary assisted dying not being prejudiced by where in the state they live.

Ms M.M. QUIRK: I have one last question on that. Why was the government not prepared to accept the amendment to this amendment, which would have given regional residents the same right to access palliative care?

Mr R.H. COOK: Essentially, this bill is about voluntary assisted dying. We believe very strongly with what the member has just described—that people in regional communities should have access to palliative care. This bill touches upon aspects of people's access to palliative care, but it is essentially a bill about a very specific aspect of the end of life—that is, voluntary assisted dying. To support that, $41 million of the package I described earlier is to provide palliative care to regional communities. I very much look forward to seeing that package implemented. It will be done under the watchful eye of the joint select committee that we have committed to establishing. Hon Martin Aldridge's amendments were specifically about people's access to voluntary assisted dying, which the member is aware is the focus of this bill.

Ms M.J. DAVIES: I rise briefly to add my comments about this amendment. As has been observed, it was moved by Hon Martin Aldridge in the upper house. It went to the heart of some of the discussion about access for regional people that we had when we debated the bill. As the minister has outlined, from our perspective it is a fundamental principle to ensure that people living in regional and remote Western Australia will have the same access as those in the metropolitan area. We thank the minister for his discussion with our upper house colleagues about how that might be incorporated into the bill. We thought it was important to have it laid out in the fundamental underlying principles so that those who will be enacting the bill will have to take it into consideration.

I understand that there was some debate on and questions about being able to deliver the service—that people living outside the Perth metropolitan area might need to access this opportunity in the same way they access specialist services. It was not something we were willing to concede. In the implementation phase a great deal of work needs to be done to make this available, considering the doctor and GP shortages across the state. That in itself will be a significant barrier and Hon Martin Aldridge spoke at some length on that. The member for Girrawheen asked a question about palliative care not being included in the bill. Our colleagues in the upper house did not agree with this either. It was because, as the minister outlined, this is a specific piece of legislation. It was commented on in the other house, quite rightly, that if we are talking about putting other principles of accessibility into this bill, we should also be talking about including services such as general practitioners, because that is a significant area of need in the state as well. We are comfortable that these principles will go to voluntary assisted dying and that some continued work on the incredibly important palliative care services—which need to be improved, as everyone has acknowledged—will be addressed outside this legislation.

Mr P.A. KATSAMBANIS: I would like to clarify this with the minister. In the debate in the other place around the insertion of this amendment, a guarantee was given by Hon Stephen Dawson representing the Minister for Health that, if necessary, the government would be prepared to fly a coordinating practitioner, a consulting practitioner,

an administering practitioner or even a care navigator to regional and remote areas to facilitate access in those places where, as the Leader of the Nationals WA pointed out, such care may not be available on tap, if you like, and services have to be flown in. The indication was that an interpreter would also be flown in or provided, as the case may be, to facilitate those services if necessary. Can the minister confirm that that assurance given by Minister Dawson in the other place is the intention of the government?

Mr R.H. COOK: Certainly, Minister Dawson was reflecting my comments in this place that we will make sure that regional residents have the same opportunities to access voluntary assisted dying as others. This came up in the context of the access to communications mediums, other than face to face. It is something that we are committed to. How that looks and how it will be implemented will really depend upon the implementation phase, and I look forward to the department being able to craft those things in a manner that does not restrict people's access.

Mr P.A. KATSAMBANIS: The amendment is based on a laudable aim that I think every Western Australian supports: that there is equal access right across our state to services that every Western Australian is entitled to receive and has an expectation to receive. In the same way as the minister indicated he would ensure that people right across the state can have access to practitioners for the purposes of voluntary assisted dying, will the minister give an assurance that he will equally be prepared to fly out palliative care specialists and interpreters to remote and regional Western Australia if a patient prefers to access palliative care specialists, either instead of voluntary assisted dying or as part of a process that may or may not lead to voluntary assisted dying?

Mr R.H. COOK: As the member would be aware, we have made record investment in palliative care, particularly in rural and regional communities. I am very excited about the prospects of how that investment will significantly improve palliative care in our rural and regional communities in a way that has never been done by a state government in Western Australia before. Clearly, our commitment to that is on the record. How that ultimately is implemented will obviously remain the responsibility of the department, which I will certainly be oversighting, and that of course will be something that the joint select committee that we have proposed would also be able to focus on.

Mr P.A. KATSAMBANIS: This is where my concern lies. As the Leader of the Nationals WA rightly pointed out, there is no legislative guarantee that residents in regional and metropolitan Western Australia will have equal or the same level of access to general practitioners. There is no legislative guarantee of access to an ophthalmologist or any other type of specialist in Western Australia, and there clearly is no legislative entitlement to equal access to any form of palliative care across the state, including palliative care specialists and other practitioners. In the original debate in this chamber, a number of us highlighted a concern that as we move further away from the metropolitan area of Perth, there is a real risk that someone who is seeking pain relief may end up being steered down the path of voluntary assisted dying, solely because it will be the only form of pain relief available in those regional or remote areas. I do not propose to overstate that fear; I do not know how much of a reality that will be in practice. What we do know is the immense difficulty that regional Western Australians, even in sizeable towns and communities, have in accessing medical care generally and general practitioners, let alone any other form of specialist. The opportunity was missed in the other place to include the same level of access to palliative care in the wording of this amendment, because, as we have discussed throughout this debate, voluntary assisted dying will be one of a suite of options available to people at the end of their life. To legislatively enshrine the voluntary assisted dying part without legislatively enshrining the palliative care part gives rise to a fear that palliative care will not be available as equally, laudable though it is that the government has provided more funds for palliative care, which is great. More needs to be done, of course. We know that more needs to be done in regional and remote areas for most health services. In palliative care, more needs to be done across the state, including in metropolitan areas. We spoke about the shortfalls before. The government has not reassured regional Western Australians that they will have equal access to the care that they need, require and deserve, given the absence of squaring off palliative care as well as voluntary assisted dying in the wording of this clause. Instead, what we see is a fear—I hope it is not realised, but the reality is that it probably will be realised—that palliative care services will not be adequate and that people who might have wanted to access palliative care in regional and particularly remote communities, either as an alternative to voluntary assisted dying or to try something before they get to voluntary assisted dying just in case it works, will be denied that access. I think that is sad. I do not expect the minister to have a solution today. When the opportunity was presented to enshrine the same level of access to both voluntary assisted dying and palliative care, as it was in the other place when it considered a suite of end-of-life choices, I would have expected that opportunity to be taken up. It is a pity that that amendment was defeated, and I place on the record my strong concern about how this will play out in practice. I hope it does not play out that way, but I have that very strong concern.

The SPEAKER: Member for Riverton.

Dr M.D. NAHAN: Does the minister have a response, first?

Mr R.H. COOK: I did not think the member was seeking a response.

Mr P.A. Katsambanis: No, I was not.

Dr M.D. NAHAN: I want to follow on from the member for Hillarys' point. This bill is about voluntary assisted dying. It is not about palliative care per se, but the two are related, as the member for Hillarys indicated. As a person moves towards the end of their life, almost without exception, palliative care is used to ameliorate pain. Often, the argument for VAD is that palliative care is not working; it is not ameliorating the pain of the patient. The two are very closely related, as the member for Hillarys points out. This amendment gives an entitlement to access VAD. We all recognise that that is very difficult to provide in regional Western Australia and, as the member for Hillarys pointed out, it is not provided in any other aspect of medicine, no matter how centrally located the patient is. The member for Hillarys asked the minister a direct question: will he, not in this legislation but otherwise, give a commitment that access to palliative care will be provided as an entitlement in regional areas—yes or no?

Mr R.H. COOK: This does not create an entitlement.

Dr M.D. NAHAN: I will read the amendment —

> a person who is a regional resident is entitled to the same level of access to voluntary assisted dying …

The word "entitled" is not an entitlement?

Mr R.H. COOK: That is correct; it is part of the principle. Obviously, the principle is that people should be entitled, but it is not, I guess, an entitlement in the form that the member used. I think we all agree that people should be able to access voluntary assisted dying. Indeed, as the member for Hillarys observed, we would like everyone to be able to access all the services that we all take for granted in the metropolitan area. There are realities about that.

Mr P.A. Katsambanis: Be careful there; come to the northern suburbs. We have gaps in the northern suburbs, too!

The SPEAKER: Member for Hillarys!

Mr R.H. COOK: I observe that we are investing significantly to fix those gaps—I thank the member for reminding the chamber about our record investment in palliative care—but this is about the principles of the bill. It goes along with other principles that we believe drive the tone and aspirations of this legislation.

Dr M.D. NAHAN: I want to make a statement about this amendment. I appreciate what the minister has just said about palliative care. My only complaint is that I wish the minister had told us before we debated this bill in this house, because many of us had an issue with the clarity of the government's investment in palliative care going forward. We only heard about this when the bill went to the other house. I assure the minister that it would have sped up the process immensely.

This is just part of the principles, and the minister is saying that people in regional Western Australia are entitled to VAD. Elsewhere, in other legislation, will the minister make that same principled statement about access to palliative care for people in regional areas? The Minister for Health oversees a whole range of different expenditure, which is appreciated. He will also have access to the report of the Joint Select Committee on End of Life Choices on palliative care generally and in regional areas. As a principle of his response to that, will he ensure that regional residents are entitled to the same level of access to palliative care as persons who live in metropolitan regions?

Mr R.H. COOK: In the same way that people are entitled to any level of health care. We all see it as a right as Western Australians to receive that care. Obviously, we do so in a way that is sustainable and makes sense for the state's system.

The SPEAKER: Members!

Mr R.H. COOK: By and large, I think palliative care in that context is like any other health service. We obviously would wish all Western Australians to be able to enjoy the extraordinary health system that we have available to us. This bill is about a specific aspect of that, and I think all members would accept that it is a particularly specific and important area. From that perspective, I think the member wanted to see that principle enlivened or recognised in this context. We agree with the member. We think Hon Martin Aldridge made some good points and we appreciate his commitment to this. He came to us with these concerns and we were happy to support him.

Dr M.D. NAHAN: The Minister for Health brought this bill to the house. It does not make any difference who submitted the amendment; it was accepted and voted on by his party also, I understand. That is the issue. There will be concerns that VAD is more accessible than palliative care in regional areas; as a result, that may give rise to a situation in which VAD is the only real option for people who are on the path to dying. I ask the minister to give an assurance to the chamber that he will ensure that regional and metropolitan people will have equal access to palliative care, as they will to voluntary assisted dying—in other words, that this legislation does not elevate VAD above other aspects of palliative care.

Mr R.H. COOK: I do not think it does. This legislation enables a particular form of end-of-life choice. The mention of it here does not diminish other end-of-life choices. The member might be making this assertion because

he might be aware that there are people who hold these concerns. I do not hold that concern. I think everyone believes in the importance of palliative care and, from that perspective, I disagree with the hypothetical that the member gave—that is, that people will seek out voluntary assisted dying because they cannot access palliative care. We have made it very clear to everyone by our financial commitment, our policy statements and through this legislation that we want people to be able to access all the range of end-of-life care choices. This bill is on a very specific end-of-life choice. Later, members will see some amendments on how patients will make these choices in the context of the availability of palliative care, which, I guess, will provide further line of sight on the scenario or hypothetical that the member has raised. I think, from that perspective, it will provide the member with further comfort on the intent of this legislation.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 2 made by the Council be agreed to.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: Mr Speaker, before I move amendment 3, I wanted to inform the chamber, as per the request from the member for Girrawheen, that amendment 2 made by the Council was offered by Hon Martin Pritchard.

I move —

That amendment 3 made by the Council be agreed to.

Mr Z.R.F. KIRKUP: I want to confirm that this is a definition for the purposes of the amendments moved by Hon Martin Aldridge in the other place. Specifically for Mandurah, noting our regional status under the Planning and Development Act, I want to confirm that under schedule 3, the City of Mandurah is considered to be regional, and that that will be the case under this legislation. I also want to confirm that this is part of the suite of amendments moved by the National Party in the other place.

Mr R.H. COOK: As the member said, this is part of a suite of amendments that were proposed by Hon Martin Aldridge. He moved amendment 1 and this is the second of his amendments. His third amendment in relation to this part of the bill is amendment 5. With the Speaker's indulgence, I will briefly speak to and clarify amendment 3, which is about the definition of a "metropolitan region", and amendment 5, which is about the definition of a "regional resident". Amendment 1 used both those terms. The Minister for Planning confirmed the point that the member made that Mandurah is a region for that particular purpose.

Mrs A.K. HAYDEN: Just on that, noting the differentiation between a metropolitan region and regional residential areas, I have a problem in Darling Range where part of the electorate is known as Peel, which is the regions, and part of it is a metropolitan region. In actual fact, the whole Darling Range seat is metro, yet under certain classifications, through planning, it is regional. Can the minister please let me know whether Darling Range can get the regional classification as outlined in this bill?

Mr R.H. COOK: I can confirm for the member that if, for the purposes of planning, the Peel region has the meaning given under the Planning and Development Act 2005, it would indeed be considered as part of the regions. As the member would understand, I am not an expert in these things, but certainly the Planning and Development Act 2005 would provide the member with some guidance on that. I would make the observation that the electorate of Serpentine–Jarrahdale was on the same latitude as the electorate of Kwinana, yet it was eligible for royalties for regions and the electorate of Kwinana was not. There are swings and there are roundabouts. I am not sure whether the member regards this as a swing or a roundabout, but that is the planning act for you!

Mrs A.K. HAYDEN: Thank you very much for that, minister. I think it is more of a roundabout, not a swing, simply for the fact that parts of Darling Range, especially Mundijong, Keysbrook and Serpentine, have a lot of elderly people who do not have the capability to get to hospitals and they have a lot of trouble getting public transport and so forth. Living down there, having palliative care, getting to hospitals and needing services are issues for them. Therefore, I seek clarification on whether it would fall into that category, because I know that people in my electorate would be over the moon if they were able to be classed as "regional" for assistance to access not only voluntary assisted dying but also palliative care. It would be greatly appreciated. I am not sure whether the minister answered my question or whether he is not really sure. Maybe he could let me know at a later stage.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 4 made by the Council be agreed to.

Ms M.M. QUIRK: This amendment inserts a definition of "palliative care and treatment". It reads —

> ***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;

Part of the delay in this house, which was odious to the proponents of the bill, was a reluctance on the minister's part to include a definition of "palliative care", even though there was such a definition in the Victorian legislation and even though the term "palliative care" was mentioned in places throughout the bill. I have gone back and had a look at the *Hansard* from the Assembly. On 3 September, the minister states —

> We have used it in the context of the principles as opposed to more prescriptive elements of the bill. The principles use "palliative care" in the broadest terms and in the contemporary common usage of the term. It is not, in that context, necessary for us to nail down the definition because it does not create an instrument anywhere else in the legislation.

Further on the same day, he said —

> … I refer the member to the fact that this clause is about broad principles that inform the rest of the legislation rather than something that might be considered an application or litigation of an issue. These are the broad principles that together inform the values that underpin the legislation. From that point of view, I do not think it is necessary to define "palliative care". I take the member's point and appreciate that he wants to nail down this aspect, but I do not think it is necessary for our bill. Of course, I cannot speak on behalf of the Victorians.

I then moved an amendment, which, of course, was lost fairly significantly. The issue then arose again on 4 September. The minister states —

> I thank the member for her amendment. As I confirmed to the house last night, palliative care is not defined in the bill, as the contemporary common meaning will apply and is associated fundamentally with the principles or values which underscore it. In the context of this bill, the term "palliative care" is used in three provisions in which it does not need defining.

The member for Morley and the member for Bunbury spoke in support of that stance. The minister concludes —

> I take the point that the member for Bunbury made. The concept of palliative care is an emerging one, and although we often picture palliative care taking place in a hospital or hospice setting, it goes beyond those simple definitions. As I said, this is not about palliative care versus voluntary assisted dying. It is not material to this bill. In the broadest possible term—that is, the generic concepts of palliative care—it is referred to in the principles, but it is not material to this bill. It does not give effect to aspects of this bill. From that perspective, I understand what members are saying in terms of it would be nice to have it in the legislation, but that is not appropriate because this bill is about voluntary assisted dying.

I am sorry to go through all that. The takeaway from all that and the short question is: why is a definition now to be inserted into the bill when the minister was so adamant—not on one day, but on two days—that it was not only unnecessary, but also, in some way, inimical to the intent of the bill?

Mr R.H. COOK: I want to acknowledge member for Girrawheen's initial amendment in relation to this. She is quite correct. At that time, we did not believe that a definition of palliative care was necessary for the purposes of the bill. Clearly, part of this is that we have had an opportunity to reflect on that debate. We have also gone out and consulted further with a range of health stakeholders and received feedback from them. As we move forward, members will see that there are other references to palliative care in the bill, particularly in relation to people having access to palliative care, so it became more useful for us to actually have a definition of "palliative care" in that context. At that time, the member was proposing the Victorian legislation definition of palliative care, which was in its Medical Treatment Planning and Decisions Act. We did not think that that definition was appropriate for Western Australia, and in the context of then coming to a view that some definition in the bill was appropriate, we sought to provide what the member observed as a more contemporary and holistic definition. This definition reflects best-practice palliative care, as understood in WA, and is consistent with the policy intent of Palliative Care WA and the World Health Organization. It reflects terminology such as "life-limiting", which is well accepted in palliative care and health care more broadly, and it is reflected in the Department of Health's "WA End-of-Life and Palliative Care Strategy 2018–28" and the Australian Medical Association's code of ethics. We landed on this particular definition. I think a definition is also provided under the Western Australian Guardianship and Administration Act, which is largely regarded as a bit outdated and certainly a bit cold. We are indebted to the member for proposing this initially, as it was foremost in our minds when we contemplated the other amendments that were put forward.

I hope the member finds that a satisfactory response. From that perspective, it is good to see that we have now at least recognised the member's intent to have a definition of palliative care.

Ms M.M. QUIRK: Again, for the purposes of the record, who moved this amendment in the Council?

Mr R.H. COOK: My apologies, member. This was ultimately a government amendment. As I said, it folds into a range of other amendments that we will consider later this afternoon.

Mrs A.K. HAYDEN: Following on from that, as the member for Girrawheen outlined, just about all members of this house debated palliative care—those who supported the bill and those who did not. There was a bipartisan approach to recognising palliative care, but every time we asked questions about palliative care, the response we received from the government, whether it was the Minister for Health, the Premier or the Attorney General, was just a simple no. I am grateful that the upper house was able to be a bit more open and deal with this legislation in a different manner. In the minister's response to the member for Girrawheen, he said that after the bill passed in this place, he did further consultation. I have three questions on that: Why was that consultation not done prior to the legislation coming to this house? Who was that consultation with? What made the minister change his mind on a topic that was debated extensively in this place?

Mr R.H. COOK: The consultation has been ongoing. The consultation took place in the work done by the Joint Select Committee on End of Life Choices and under the Ministerial Expert Panel on Voluntary Assisted Dying and I continued to undertake it throughout the life of this bill. I will comment later on the discussions we had with the Australian Medical Association, which, quite frankly, came to this whole debate a little late. We incorporated a lot of the AMA's concerns. I do not know whether this was specifically an issue that the AMA raised with us, but, certainly, there had been a range of discussions around this issue, and, of course, I note that the member for Girrawheen originally raised the issue. As I also observed, this will be of some note in the context of other amendments have been made.

Mrs A.K. HAYDEN: To clarify, the minister said that the AMA came to the debate a little late. Was the minister not engaged with the AMA prior to that? Again, the minister did not answer the other part of my question. What changed the minister's mind? What was the argument from the AMA or whomever else the minister consulted with?

Mr R.H. COOK: The AMA's discussions with us over specific clauses happened late in the piece. I have been talking to the AMA ever since the idea was mooted many years ago now. From that point of view, we had the opportunity to talk with the AMA about a more detailed examination, and that largely followed some work that it did with its membership around specific clauses that it had concerns with. As I said, we had the Joint Select Committee on End of Life Choices, the ministerial expert panel and extensive conversations with both people who have been involved in end-of-life choices as part of their personal journey and people who are experts in the field, particularly in palliative care. I do a lot of work with Palliative Care WA. From that perspective, I guess, ultimately, after the debate I had cause to reflect on the great work that the member for Girrawheen had done in her cross-examination of the bill. I want to acknowledge the time that she spent on this as well. A number of ideas or consultations enlivened these amendments. As we go through the bill, the member will see more amendments that people have brought forward, which, quite frankly, we have an opportunity to look at and go, "It seems like a fair thing."

Mrs A.K. HAYDEN: I have a last question on this issue before I let my colleague get up. Everyone in this place had a problem with palliative care, and, to be honest, I thought the way we were all treated during that debate in this house was appalling. Our concerns were dismissed and quite a few times I was told that I was asking dumb and stupid questions. We now see these amendments that were moved in the other place and were accepted by the government and the minister is now acknowledging the great work of government members who, like most members in this place, put in a lot of time and effort into their deliberations and consideration of this bill. Does the minister not think that he owes everyone in this chamber an apology for the way we were treated? The government did not deem that one amendment was necessary. The minister, the Premier and the Attorney General said that this bill was perfect and did not need any amendments, yet 55 amendments have come back to this place. The way the other place treated this legislation was far more professional; it was democratic and showed proper due process to our system. I think this house failed to do that with our consideration in detail stage. I note that this amendment started when the member for Girrawheen and just about every other member in this house raised concerns about palliative care. In my opinion, every member in this place was treated appallingly over the last few days of this debate and they deserve an apology.

Ms M.M. Quirk: Member, I don't need one.

Mrs A.K. HAYDEN: I do.

Several members interjected.

The SPEAKER: Members! None of you need anything at the moment, the minister is on his feet.

Mr R.H. COOK: Thank you, Mr Speaker. I put on the record that none of the amendments that we are considering today detract from the integrity and the intent of this bill. The amendments that we are considering today come from a range of sources and, on the whole, simply enshrine what is already good medical practice or makes explicit what was essentially implicit in the bill. They are important amendments because we want to make sure that, going forward, people will have confidence in this legislation.

I am sorry if the member believes that people thought her questions were dumb or stupid. That was not the intent of our response, and I certainly place on the record that I have never suggested that the member's questions were stupid or dumb. From that perspective, member, we live and breathe this legislation. To paraphrase, or borrow an analogy, to a certain extent we live and die by the amendments and by the legislation that we have before us. Often in the field of battle, we cop the odd slice or two, and we get up and we fight another day. I think this legislation was appropriately dealt with. We are very happy to acknowledge the amendments that have been made. There are 55 amendments, 25 of which were moved by Hon Nick Goiran, 18 from the government and we also have amendments from Hon Alison Xamon and Hon Martin Pritchard. We have seen already some of the amendments from Hon Martin Aldridge. We are considering a range of amendments today that take into account all perspectives on this legislation and I think it continues to be a good piece of legislation.

Mr P.A. KATSAMBANIS: The amendment before the house is the first of the amendments moved in the other place by the Minister for Environment on behalf of the government. Taken in isolation, the amendment that has come back to this place before us should be a real celebration of parliamentary procedure. It should be a credit to all of us that a piece of legislation produced to the Parliament is essentially not an official government bill. The bill was introduced to Parliament, it was considered by both houses and it was improved by amendment—so all well and good. I think we all agree that this amendment is an improvement to the bill. That is the point that was initially made by the member for Girrawheen when moving what was substantially the same amendment as the one we are agreeing to today back when we started this entire process and we considered clause 5 three months ago. However, when we look at the entirety of the process, it is unfortunately not a celebration of parliamentary procedure; it is really an illustration of the worst processes of Parliaments, when legislation is rammed through based on numbers rather than logic or good public policymaking.

I fully agree with the words of the minister in his contribution a moment ago when he said that this amendment does not affect the integrity of the bill. That is what the member for Girrawheen said back when we considered her amendment at clause 5 during the consideration in detail stage, and that is what the other members who supported the member for Girrawheen's amendment back then said—that it would not affect the integrity of the bill; in fact, they said it would improve it in a critical way. We have discussed the intersection between palliative care and voluntary assisted dying and the need to ensure that there are appropriate end-of-life choices for all Western Australians. But what happened back when the member for Girrawheen proposed this amendment? There was not universal acclaim, there was not support, there was not cheering and clapping, and there was not acceptance. I do not want all that cheering and clapping; I do not particularly like all that sort of stuff. What I wanted was an acceptance of a logical and sensible amendment to a critically important bill that deals with the most difficult subject that any of us have ever dealt with in our parliamentary careers. I wanted an appropriate and fair consideration of this amendment, and it was not given that; it was dismissed out of hand. Nothing highlights that dismissive approach more than some of the comments the Premier of this state made in his contribution to the third reading debate back on 24 September when he said —

> Amendments were handled in a timely manner and given proper consideration by the minister and the Parliament.

Well, if they were given proper consideration by the minister and the Parliament, why are we here debating this amendment now? They were not. I do not blame the minister for that. I think the minister has handled himself with the utmost integrity throughout this entire process—from the time the legislation was first tabled in this place right through to today. I think he should be proud of his performance and achievement. I think his stature in the eyes of everyone in this place and every Western Australian has risen. I think he knows that I already had a very high opinion of his capabilities, but it has risen throughout this entire process. Unfortunately, the machinations happening behind the minister stymied that proper consideration and the amendment was dismissed out of hand and crunched on the numbers, rather than being based on good public policy. That is not good.

Dr M.D. NAHAN: I am really enjoying the comments of the member for Hillarys. Could I hear more?

The DEPUTY SPEAKER: Yes, you may. Go ahead, member for Hillarys.

Mr P.A. KATSAMBANIS: The Premier continued his contribution to the third reading debate by saying —

> This is good legislation. It is very well drafted and carefully considered. The government has devoted a huge amount of resources to this bill. It does not require amendment. It does not require further frustration and delay from an additional inquiry.

I agree that a huge amount of resources were devoted to the bill, but I do not agree that the bill does not require amendment, and neither does the house. We are here, collectively as the Legislative Assembly, effectively repudiating the Premier's comments, and doing so unanimously. We are repudiating them. As much as this debate has enhanced the status and stature of the Minister for Health, it has diminished the standing of the person who should be the leader of our state and who should be leading by example—the Premier. During the third reading debate, the Premier's words summed up the worst of parliamentary procedure—that battering-ram approach in which logic and sense goes out the window and it is us and them. It is almost as though there is a football team on one side and a football team on the other side and we want to crush that other team. That does not get good outcomes. I have pointed out before in this place and I will point out again that the other thing it does is diminish our standing collectively in the eyes of the public, from what was already a low base. It is probably the lowest base that I have seen in my 35 years in public discourse and involvement in the political process. It does not stand us in good stead at all, especially when it comes from the office of the Premier, because it just makes the public wonder whether we are here to serve their purposes or because we like to play silly games.

This is the first of a number of amendments proposed by the government in the other place that really ought to have been properly considered when they were put here by other members, and primarily by members of the governing party. People are exercising their conscience in this debate and are not voting on party lines. That is good. I personally think we should have more of that. But in this particular case, I did not want to miss the opportunity of highlighting this. This should be a celebratory moment, but it is not, because people were essentially shouted down, smashed on the numbers and in many ways bullied and abused—none more so than the member for Girrawheen and the member for Darling Range, as she pointed out in her contribution, for standing up and supporting not just this principle but also an amendment that will now be unanimously agreed to by both houses of Parliament. We ought to reflect on whether this entire process could have been handled better. I am not going to make the same points again when we consider the other amendments, but I thought it was really important to make that point here today. On reflection, the government went away and thought it was a good idea. It would have been better if that reflection had happened earlier. It would have avoided a lot of nonsense—a lot of toing and froing—and we would have been in a better place. I think the public would have seen the greatness of a democratic Parliament and would have focused on that greatness rather than on the five per cent of our work that is adversarial and sometimes demeans us in the eyes of the public.

With that, I commend the member for Girrawheen for her persistence in bringing this matter to the fore and for supporting it through the process; I commend Hon Nick Goiran, who brought this forward in the other place; and I commend the government, through the offices of both the Minister for Environment and the Minister for Health, for agreeing to this amendment in the end, because it is logical, it is sensible and it improves the bill in significant ways. I hope that when we do these sorts of things in the future, we do not do them in the difficult way we have done them this time.

The DEPUTY SPEAKER: The question is that amendment 4 be agreed to.

Mr S.K. L'ESTRANGE: Madam Deputy Speaker.

The DEPUTY SPEAKER: Is it a different topic, member?

Mr S.K. L'ESTRANGE: No, it is the same the topic.

The DEPUTY SPEAKER: I think we have a repetition issue.

Mr S.K. L'ESTRANGE: There is no repetition here; I have not said anything yet.

The DEPUTY SPEAKER: Member, I just asked whether you are going to talk about the same points as the other two speakers.

Mr S.K. L'ESTRANGE: No, it is not the same point, but it is the same amendment.

The DEPUTY SPEAKER: That is fine. I specifically ask you not to repeat the substance of the contributions of the previous two speakers. Go ahead, member.

Mr S.K. L'ESTRANGE: We have just heard the member for Hillarys talk about how we were treated in this place the last time the bill was before us, and now I have been verballed by the Deputy Speaker before I have even opened my mouth.

Several members interjected.

The DEPUTY SPEAKER: Member, would you like to ask your question, please?

Mr S.K. L'ESTRANGE: I would.

The DEPUTY SPEAKER: Go ahead.

Mr S.K. L'ESTRANGE: The last time we debated clause 5 in this place, both government and opposition members said that "palliative care" needed to be defined in the bill. The minister told us time and again that it did not. One of the key points we raised about the bill was in relation to clause 26, and I heard in the minister's answers to members today that there has been cause for some reflection. Clause 26 is headed "Information to be provided if patient assessed as meeting eligibility criteria" and it existed when we were last in this chamber. It is clear, and states —

> (1) If the coordinating practitioner is satisfied that the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters —
>
> …
>
> (c) the palliative care and treatment options available to the patient and the likely outcomes of that care and 18 treatment;

We said that the bill needed a definition of "palliative care" because of clause 26 so that in the context of that clause, people could go to the definition and know what it meant. The member for Girrawheen moved an amendment containing a definition of "palliative care", which stated that "palliative care and treatment" means 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 one disease, illness or medical condition that is advanced, progressive and incurable, and will cause death. The minister's responses—I will paraphrase him—were that palliative care is not defined in the bill, that he respectfully submitted that it did not need a definition of "palliative care" to meet the needs of the bill and that, ultimately, he would have some difficulty with the wording that the member used. He came to the key point that a definition of "palliative care" was not needed. This has now come back to us and I ask the minister the following question: given that the minister said that a definition of "palliative care" was not needed and that his government moved an amendment to say that a definition is needed, does the minister stand by his original words that one is not needed or does he agree that it is now needed?

Mr R.H. COOK: The member will see from the schedule from the other place that there is now reference to "palliative care" in amendments 18 and 25. In addition, there is also reference to it in relation to matters upon which the Voluntary Assisted Dying Board must now report in the context of these. There is substantially more reference to palliative care and from that perspective it became clear that a definition of "palliative care" would be useful. Members, there are always going to be differences of opinion about what is necessary and unnecessary in legislation. Indeed, this legislation has evolved and from that perspective the government had cause to reflect upon the amendments moved, albeit in a different context, but that context has essentially changed. In the context of the debate that took place here, everyone had an opportunity to express their views and if their particular view did not enjoy the majority support as it existed at that time, that is a proper reflection of the parliamentary process. We have a range of amendments before us that go to the issues of access to palliative care and from that perspective, we now believe, on balance, that it is appropriate that a definition be included in the bill.

Mr S.K. L'ESTRANGE: Does the minister think that it is very dangerous and unhelpful to define medical terms and treatments in legislation?

Mr R.H. COOK: The definition in front of the member is appropriately worded in a broad sense and does not try to create a clinical definition, which would be inappropriate. It refers to the type of treatment.

Mr S.K. L'ESTRANGE: The definition is clear and the term is "palliative care and treatment" so that is what it is titled and that is the government's definition. The member for Morley stated that it was very dangerous and unhelpful to define medical terms and treatment. Does the minister agree that it is dangerous to define medical terms and treatments?

Mr R.H. COOK: I have answered the question. The definition is appropriate for the purposes of the legislation. If the member for Churchlands has an issue with something said by the member for Morley, he is entitled to take that up with the member.

Mr S.K. L'ESTRANGE: I was asking for the minister's opinion, not that of the member for Morley.

The member for Bunbury said that the inclusion of a definition of "palliative care" in legislation will put an artificial constraint on what palliative care could and should be. Does the minister think that the government's definition will put an artificial constraint on what palliative care could and should be?

Mr R.H. COOK: No, because we have taken a best practice definition in the broadest terms possible. We consulted a range of different sources about the definition.

Dr M.D. NAHAN: I support the amendment. I assume that the government has done a great job with the wording of it. I want to make a comment about this process. The Voluntary Assisted Dying Bill 2019 is the most difficult piece of legislation that I have had to confront in my almost 12 years here. It is an issue of morality, religious views and adequate governance. It goes to the heart of some of the most difficult issues we face in humanity. When I was the Leader of the Opposition, I praised the government for bringing this legislation forward. It was the right thing to do. The public wanted the debate. They do not know the detail of it; to a great extent, that is our job. Both parties said quite rightly that there would be a conscience vote. This is very contentious; some people are strongly against it and others are strongly for it without any limitations. There is a diversity of opinion and it is a necessary debate to have. To some extent, apart from Victoria, we are leading the way in Australia. I came to this debate after discussions with a great many people and with my value sets. I supported VAD but I had three major issues with the bill, which I raised over and again. One was the adequacy of palliative care funding. The evidence provided to us at that time showed that it was not adequate. In that debate we urged the government to increase funding of palliative care in parallel so we could support the bill—I could support the bill. The second thing was to ensure that voluntary assisted dying was put into the context of palliative care, because it is in context. Obviously, the government was trying to say that it was a separate issue. Part of that was a definition of "palliative care", and it looks to me that we will get to that later at amendments 18 and 25, which put VAD in the context of palliative care. That is all good and fine.

I would like to support the comments made by the member for Hillarys about the minister. I think the minister has appropriately carried his responsibilities with his leadership of this debate and, I might add, the way he has performed outside and inside this Parliament. He has dealt with a difficult bill in an appropriate way. But I want to quote something from the Premier, who is the leader of the government and who promotes this bill. I quote an article in *The West Australian* of 5 September 2019. It says —

> Premier Mark McGowan has accused MPs of filibustering on assisted dying laws after late night sittings of Parliament saw the bill hopelessly bogged down in debate on technical details.

A lot of those relate to issues that I and others have about palliative care. When the bill was passing through this house, the government refused to address the adequacy of palliative care or to address it in amendments. We discussed it at length, as we should have done. These amendments before us today prove that we were right. I understand democracy, and I understand that the numbers were tighter in the upper house. The government held back amendments until the bill got to the other house. The Premier told the public that we were purposely filibustering, slowing up the debate, in this house and staying late at night, which was the Premier's choice, trying to stop the passage of the bill. Now we are sitting here in December effectively voting for amendments that we argued for but that the Premier said was filibustering. It seems to me that the person who has been filibustering all this time is the Premier. A significant number of people have come to my electorate office and asked me why we were holding back this legislation and why we were unnecessarily filibustering if we supported the principle of VAD. I explained that the Premier was misleading the media both on his actions in this house and our approach to the bill. Hopefully that explained things to them, but of course I cannot talk to all the people. In other words, I would like to make a complaint about the Premier in this house.

Mr P.A. KATSAMBANIS: I would like to hear more from the member for Riverton.

Dr M.D. NAHAN: The Premier, quite contrary to the spirit of much of the debate in this house, talked to the media about us. I think it was generally accepted, and not just on this side, that we had to do more in relation to palliative care. The government reacted soon after the passage of this bill through this house; it allocated more money and had to really put VAD in the context of palliative care. That included the definition of "palliative care" and other amendments, which are now being put in the bill. We will now pass that through this house. The Premier told the public of Western Australia that the opponents, people who were not voting for the bill as brought to this house, and as it passed this house, were deliberately trying to stop VAD from passing through this Parliament—that is, unnecessarily filibustering. That was false. The amendments we are dealing with show that to be the case. The minister said that the Australian Medical Association and the palliative specialists lobby group—he did not say which—were late to the party on this. They were not. Maybe they were late to the minister, but they sure made their requests and concerns well known to us—repeatedly. That included having the definition and putting VAD in the context of palliative care. I know I am not pointing out a disagreement, and I expect these amendments to pass through this house quite quickly. I understand that sometimes it takes amendments in the upper house to tighten the political process, but the Premier misled the public about the actions of his government. He misled in debates in the Parliament, and he told the public through the media that we were unnecessarily holding back the bill on technical and irrelevant issues just to stop it, which was false. In the process of doing so, he has undermined public support for VAD and he has undermined public support for Parliament. He has let us all down badly.

Mr R.H. COOK: I just want to clarify two points. The member just made the comment that I said the AMA and the palliative care community were late to the debate. That is not the case. I have engaged with the palliative care community all the way along, and I maintain that. The reference I made to the AMA coming late to the debate is

that it did a second survey. The AMA did an initial survey of members about their views, and that drove its policy positioning. Then it did a second survey of members about specific aspects of the bill, and that is when it came to us to discuss specific details of the bill.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 5 made by the Council be agreed to.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 6 made by the Council be agreed to.

Dr A.D. BUTI: Obviously, new clause 9A moved by the government and passed in the other house relates to some of the issues I raised in debate on an amendment I had moved that was similar to this. This amendment does not go as far as I would have liked to go, but, as Mick Jagger said, "You can't always get what you want"!

Mr R.H. Cook: The question is, member, did you get what you need?

Dr A.D. BUTI: In the end, it is really not about what I want; it is about what I thought was appropriate to be in the bill for the citizens of Western Australia. As the minister knows from the debate on the amendment I moved, my main concern was the possibility of undue influence on people, especially vulnerable people who may be easily led by people in positions of power. As we know, there is a presumption of undue influence between a doctor and a patient. This amendment still does not address the issue of the medical practitioner, the doctor and/or nurse, being able to initiate the topic of voluntary assisted dying, and, of course, I am disappointed about that. When I moved the amendment, people said to me that having this restriction was going to affect the ability of uneducated or working class people to access VAD. I did not find that a plausible argument. It would be hard to find anyone in Western Australia who does not know about VAD. People said that it had become a problem in Victoria. It is hard for it to be a problem in Victoria when the legislation has been in operation for only about two or three months. There has been no evidence gathered that people who want to access VAD cannot access it. But anyway, so be it.

I am very, very happy that the minister has moved that this amendment be agreed to, to the extent that we have reduced the number of those who can initiate the discussion. That was the other part of the rationale for my amendment. One part of it was the power imbalance and the other was the range of people who were able to initiate the discussion—that is, any carers or health professionals. To say that we should not look at that is turning a blind eye to the Royal Commission into Aged Care Quality and Safety. The stuff that has come out about aged care tells us that people in nursing homes are vulnerable. It would not be beyond possibility that people could be coerced into using VAD. I support VAD and I supported every single clause of the VAD bill. I just wanted this amendment to be made. The whole issue of voluntary assisted dying is that it is voluntary—"voluntary" means without coercion or undue influence. That was the rationale behind moving my amendment. It did not get up in this house or the other house, but I congratulate the minister on the way he has handled it since then and tried to reach a compromise. I thank him for the discussions he has had with me. I can at least rest a little easier in the sense that the range of people who can initiate the discussion has been reduced. As I said, this amendment does not go all the way, but it is better than what we had, so I thank the minister very much.

Mr R.H. COOK: I did not speak to this amendment when I moved it, but perhaps I should do so to provide context and because the member for Girrawheen requested to hear who moved the amendment in the other place. This amendment was moved by the government in response to a range of discussions that took place with stakeholders and members of Parliament. I acknowledge the member for Armadale and Hon Jim Chown in relation to this amendment. I will correct one thing the member for Armadale said, because it is an important distinction. This amendment will limit the health professionals who can initiate a conversation about voluntary assisted dying to a medical practitioner and a nurse practitioner—not an enrolled nurse nor a registered nurse. That is an important distinction to quantify the number of people who can raise it. This amendment will restrict the number of people who can initiate a discussion about voluntary assisted dying. It also explicitly states the context in which that conversation must take place. To quote the legislation, it must include —

(a) the treatment options available to the person and the likely outcomes of that treatment; and

(b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

Those two elements are important. The number of people is restricted and we are making sure that it will be done in the proper context and that the person is made aware of their full range of care options.

Member for Churchlands, this new clause is another example of palliative care being referred to, which comes back to the issue of whether we need a definition of "palliative care and treatment". I thank the member for Armadale for his comments. This amendment was in direct response to the concerns that he raised. I could not agree with his amendment, but it inspired this amendment. If it goes some way to ameliorating his concerns, I will be very pleased. Thank you.

Dr D.J. HONEY: The minister will know that I have an interest in this area. I am still intrigued by the government's response to this issue. As the minister has stated, this amendment goes some little way, but I do not think it goes anywhere near far enough. Because of the debate that took place here, the minister and the Attorney General would know that there is a doctrine of presumed undue influence between medical practitioners and patients. That doctrine is that if a doctor gains any benefit at all from a patient, it is presumed in the first instance that the patient has been subjected to undue influence by the doctor because of the special relationship between a doctor and a patient. That special relationship was articulated very clearly and, I thought, very movingly, by the member for Armadale. When doctors suggest something to a patient, it may well be that the patient will embark on a course of action that they would not otherwise have taken of their own volition. That is the reason a similar provision was excluded in the Victorian legislation, and the member for Armadale, other members and I made the argument in this place that we should not allow this to happen. Given that in similar circumstances we presume a doctor has a special position and can exercise undue influence in a matter, I wonder why the government has persisted in allowing a doctor to suggest voluntary assisted dying to a patient. As the member for Armadale said, narrowing the scope of this provision might go a little way towards dealing with this issue, but the truth is that the relationship of greatest concern and with the greatest potential imbalance of power is the relationship between a doctor and a patient. One of the consequences of this bill, as it is manifest, is that a person may undertake this process because their doctor suggested it and they feel that it is something they should undertake rather than something they want to undertake of their own volition. I wonder whether the minister could tell us why the government has persisted with this. I see allowing this to occur as a dangerous shortcoming of this bill.

Mr R.H. COOK: The proposed new clause has been included following discussions with the Australian Medical Association and it reflects good clinical practice within the current holistic context in which medical and nurse practitioners discuss medical options with patients. As I said, it reflects good clinical practice. A range of amendments members will see today explicitly mention good clinical practice. The member for Cottesloe sees this as a weakness in the bill, but I see it as one of its strengths. It clearly sets out the solemn responsibilities and obligations of a medical practitioner in providing care to a patient who is facing end-of-life choices. From that perspective, I disagree with the member that it creates a weakness in the bill. I think it is a very strong amendment that goes some way to alleviating the concerns that were raised.

Mrs L.M. HARVEY: I differ from my colleague's perspective on this new clause and I thank the minister for including it. This new clause is tied with the amendment to clause 2 setting out the principles of the bill that there is a need to protect vulnerable people from abuse and/or coercion. If we read it in the context of those principles being reworded and reset, this new clause is a significant improvement to the legislation. I am pleased that it has been considered, although I accept that it may not go far enough for some members. I would like to put on the record that I am pleased that it clearly outlines that a doctor or medical practitioner having a conversation with an individual about voluntary assisted dying needs to include a conversation about the options for care and the likely outcomes of those options. It will be clearly defined in the legislation.

I think most members would agree that this is a much stronger protection than a referral to the regulations further down the track. I also accept that this bill has a long way to go in the implementation phase and that regulations may well be required to more clearly define how those conversations may occur and what may need to be included. I am pleased that this new clause is here. Its inclusion and the other 54 amendments on the notice paper have given me great heart in being able to step forward and vote in favour of this legislation. I thank the minister for including this new clause.

Mr R.H. Cook: Thank you, member.

Ms M.M. QUIRK: I am very grateful to concur with the remarks of the member for Armadale. I will say one thing about the insertion of new clause 9A(3), which is, effectively, a compromise position that was moved in the upper house. The fact that there will not be real-time oversight is the reason that I considered the original amendment moved by the member for Armadale as more appropriate. It would have removed any ambiguity whatsoever. That said, this is what we have. I have just a technical question.

Proposed subclause (6) states —

> Subsection (5) overrides section 10(1).

I am not quite sure about the implication and impact of that. There is obviously a simple answer, but it is not readily apparent to me. I would be grateful if the minister could explain why subclause (6) is necessary.

Mr R.H. COOK: This is a stronger position than that in clause 10 of the bill, which states —

> (1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct …

A contravention of proposed clause 9A must be deemed unprofessional conduct.

Ms M.M. QUIRK: In relation to the conduct sought to be controlled under new clause 9A, the standard is higher than for other possible contraventions. Is that the correct interpretation? If that is not the correct interpretation, why does clause 10 need to be there at all?

Mr R.H. COOK: I am advised that the standard is not higher, but it is creating a definitive definition of misconduct. It is a mandatory breach, not a discretionary breach.

Mrs A.K. HAYDEN: I refer to proposed new clause 9A(3) and note that this entire amendment was originally brought on by the member for Armadale in this chamber. It was not accepted, even though he gave an extremely compelling argument. When I looked around, I do not think I saw a dry eye in the chamber; everyone felt the emotion he was putting out there, and my heart went out to him when his amendment was not accepted. I note that Hon Martin Pritchard then tried to move that amendment in the other place, and it was sadly lost again. I think the vote was 9–23. However, the government then put up its own amendment, which did not go as far as the original one but addressed some of the issues. I also note that an amendment to the minister's amendment was made on the floor, put up by Hon Nick Goiran. I am pleased the government accepted that, because that one little change—which, unfortunately, people thought was time wasting—has made a massive difference to this amendment. I will read it out for members and for the *Hansard* record. It states —

> (3) Nothing in subsection (2) prevents a medical practitioner or nurse practitioner from doing something referred to in subsection (2)(a) or (b) if, at the time it is done, the medical practitioner or nurse practitioner also informs the person about the following —
>
> (a) the treatment options available to the person and the likely outcomes of that treatment; and

This is where the change was. It originally said "or" instead of "and". It continues —

> (b) the palliative care and treatment options available to the person and the likely outcomes of that care and treatment.

The amendment put up by Hon Nick Goiran and carried on the floor by the voices changed "or" to "and", and means that they now need to inform the person about not only the treatment options available, but also palliative care and treatment. Others may mock that, but, to me, that put in an extra safeguard that this legislation needs. I want to put on the record that I am glad that the minister in the other place saw fit to do that and I am happy that it went through and that we are here to pass that amendment today. I close by noting that I wish the member for Armadale's original amendment had been accepted. I think it would have been a far better amendment. Also, out of respect for a very dedicated, hardworking individual, it would have been good to see his amendment passed.

Mr P.A. KATSAMBANIS: I made a number of comments both during the debate on the original amendment that was brought to this house by the member for Armadale and in my contribution to the third reading. I re-emphasise the comments that I made by thanking and congratulating the member for Armadale for bringing forward the amendment. I point out that certainly in my time in parliamentary chambers, plural, across two states, it was probably the most—I hesitate to find the right word—personally challenging contribution I have ever heard anyone make. I thought, and still think, that it was a very, very important safeguard that the original legislation was lacking. Unfortunately, that amendment has not come to pass as part of the legislation that will be implemented in this state. I still think that is a major failing. I will not retrace my reasons for that—it is on the public record and other members have made that point today—but it is a major failing and a major pity that that amendment was not supported in either this chamber or the other place. I think it would have improved the bill markedly.

Having said that, the amendment before this chamber now, which was approved by the other place, also improves the bill quite significantly. It highlights what many of us said during both the second reading debate and the consideration in detail stage in this chamber—that aspects of this bill were not only wrong, but also dangerous. Although this amendment does not provide the level of protection that ought to be provided and could have been provided had the member for Armadale's amendment been adopted, it adds a layer of protection that was not in the bill as passed by this chamber. Again, it highlights both the best and worst of parliamentary procedure. It highlights that members are prepared to stand up and say, "We can do better than this", and it highlights that the chambers can agree to something that improves legislation, especially in this critical area, and provides real protections for very, very vulnerable people. It closes the group of practitioners who can, unprompted, suggest voluntary assisted dying without the patient requesting it. It does not close it off completely, which I think would be better. The member for Armadale obviously thought that would be better and other members thought so, too. The majority of people did not want to agree to that, so that was a pity. Even though I would have preferred the member for Armadale's

amendment to have succeeded, as I said, this amendment will provide a safeguard and level of protection for vulnerable people that was clearly not in the original bill; therefore, I support it.

Dr M.D. NAHAN: I also support the amendment. My reading of it is that this is a completely different amendment from the amendment the member for Armadale brought forward, which I would have liked to have been passed, but it was not, neither in this chamber nor in the other. However, this is a very appropriate amendment. I would also like to re-emphasise one of the issues. There are a number of points. Indeed, healthcare workers will be limited in their ability to suggest VAD in the first instance, and it will also make sure that VAD is more clearly put forward by the appropriate people in the context of palliative care and treatment, which were arguments that some of us made extensively. I want to go back to my point about our role, as the Legislative Assembly, in the development of this debate. It was not just the Premier who was very critical of us debating this issue. This was one of the most extensively debated issues by the Legislative Assembly—late at night, if I remember correctly. One of the accusations by the Treasurer was that all that members of Parliament were ultimately doing, in trying to slow down the passage of this legislation, was standing in the way of Western Australians who might want to take advantage of the choice that this legislation will give them. In other words, the Treasurer was saying that by debating these specific issues we were trying to stop people who might in the future want to access VAD. The amendments that we are going through today show that to be false. We were trying to raise points and bring forth amendments in the Legislative Assembly, which is our right and responsibility, to improve the bill. The amendments coming through this place today are a validation of that. Both the Premier and Treasurer accused the opposition of purposely trying to slow the progress of the bill and, as a result, stop people from accessing VAD. Those accusations were false and inappropriate. The fact that we are here today, dealing with amendments that we suggested and argued for, is proof of that. The amendments were specifically meant not to slow down the bill, but improve it. The fact that we are here today shows that the government has played politics with this bill, rather than putting forward a good bill.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 7 made by the Council be agreed to.

Just to speak briefly to this amendment, this is a small amendment suggested by Hon Alison Xamon. It reflects outdated language that we were using in the term "commit" suicide. The legislation was quite appropriately corrected to state "die by" suicide.

Question put and passed; the Council's amendment agreed to.

Mr R.H. COOK: I move —

That amendment 8 made by the Council be agreed to.

This is a suite of amendments that were moved by Hon Nick Goiran and agreed to by the government. These amendments join other amendments. This is amendment 8, and it goes to amendments 9, 12, 21 and 30, which give effect to this particular amendment. It is essentially to prohibit certain persons from carrying out particular roles under the bill if they are a family member of the patient or if they know or believe that they will be a financial or material beneficiary from the death of the patient. This amendment goes some way towards enshrining good clinical practice and provides clear lines of delineation between the patient and participating practitioners and persons. In situations in which a patient is referred to a registered health practitioner or person, that practitioner or person will be required to advise whether they are a family member of the patient or whether they know or believe that they will benefit, financially or materially, from the death of the patient. It will not be incumbent upon the assessing practitioner who makes the referral to make those checks.

Mr P.A. KATSAMBANIS: I note that the minister said that this amendment and the consequential amendments that follow were moved by Hon Nick Goiran. I would just like to point out, for the correctness of the record, that Hon Nick Goiran actually moved a very similar amendment that was defeated in the Legislative Council. The government then, through the Minister for Environment, moved this amendment—which, as I said, is similar to the one that was moved by Hon Nick Goiran—and again proved the political maxim that you get a lot more done if you do not want to claim the credit for it. But it should not pass without saying that, regardless of who ended up moving the amendment we are considering now, the substantive issue was raised by Hon Nick Goiran.

Again, this is a very, very important safeguard and protection relating to an actual conflict of interest of the medical practitioner that did not exist in the original bill. These matters were pointed out in this place during the second reading debate and in consideration in detail, but were dismissed out of hand. The original amendment has now been altered, and it is sensible. Good on the government for recognising that it was a genuine issue and amending it. It might not have liked the words that Hon Nick Goiran used, and that is fair enough, but the effect of the amendment is, in substance, exactly the same as that proposed by Hon Nick Goiran. As I said, some words might have been changed, but the amendment improves the bill by protecting vulnerable people from actions that might

be taken by people who might have an actual conflict of interest or could be perceived by any reasonable third party to be subject to a potential conflict of interest. I hope the amendment has everyone's support.

Mr R.H. COOK: The amendment that has been moved was substantially moved by Hon Nick Goiran. We tidied up some of the words from a drafting perspective, but it is substantially the amendment that he moved.

Mrs A.K. HAYDEN: Following on from the member for Hillarys, the government has put this amendment forward. It was raised during the debate in this place. The biggest concerns were put, and I remember one of the arguments was the issue of elder abuse. As we know, elder abuse is, unfortunately, increasing across our state and has become the new domestic violence; it has reached the point that domestic violence reached 20 years ago. People are not talking about it and are too scared to come forward. That argument was put at some length during debate in this place. Some members in this place were fearful that elderly people diagnosed with a terminal illness and eligible to access voluntary assisted dying could be coerced, bullied or pressured by loved ones into accessing it. That is why this amendment is actually extremely important. It fills a gap that we thought this legislation had. Sadly, like all the other suggestions that were made in this place, it was ignored and deemed unnecessary. I believe the minister even went as far as saying that the bill was already good legislation, that a lot of work had gone into it and that no changes were required. We stood here for many hours, raising the need to protect the most vulnerable people in our community, and although that was ignored and fell on deaf ears in this place, I am pleased that it was picked up in the other place. Although the amendment moved by Hon Nick Goiran was lost, the government saw fit to bring its own amendment.

That is what we, as legislators, are all about. We are here to make sure that every piece of legislation that passes through this chamber will not have any loopholes or unintended consequences. As I said in my contributions to the second and third reading debates, if, under this legislation, one person who does not want to die does die because they are bullied or coerced, it means that this legislation is not worthwhile. That is why we were so passionate about raising these issues in the debate. Again, these amendments pick up on that. It is fantastic to see that beneficiaries will not be in a position to bully or coerce. We all know that that may happen from time to time; not all legislation will ever be perfect. It is important to acknowledge lessons in life, and one of them is that a government should never come into this place saying that legislation does not need changing. When we have to come back and amend it, we can be sure that no matter who said that, there will be someone reminding them, "We told you so, and it needed changing." I think that is a lesson that everyone in this place needs to understand for true democracy. We need to make sure that everyone's concerns are considered and not simply ignored and batted away. We went through many hours of debate in this place, and many people raised concerns about elder abuse and coercion into voluntary assisted dying. Issues were also raised about financial beneficiaries being involved in the process. It is great to see this amendment. As I said, it was ignored in this place, but it was picked up in the other place and I suppose that proves why we need two houses. I know many people in the state say that we should abolish the upper house, but this legislation has proved why we need two houses and to stick to our bicameral system of the Westminster system in Western Australia.

An opposition member: Withdraw! Withdraw!

Mrs A.K. HAYDEN: I will not withdraw that—I am sorry! We are pleased to see that this amendment has been put forward. We are pleased to see that we are now going to be protecting our seniors, elders and anyone else who could be put in a very uncomfortable position.

Debate interrupted, pursuant to standing orders.

[Continued on page 9975.]