

GUARDIANSHIP AND ADMINISTRATION AMENDMENT (MEDICAL RESEARCH) BILL 2023

Second Reading

Resumed from 23 March.

DR J. KRISHNAN (Riverton — Parliamentary Secretary) [12.56 pm]: I rise to make a short contribution to the debate on the Guardianship and Administration Amendment (Medical Research) Bill 2023. Medical research is a very important area in which there are two aspects. The first is to support medical research with funding and the second is to make its systems and processes work so that people are encouraged to take up medical research. I refer to the first aspect. Last week, during question time, the Premier made a very clear statement that the Cook Labor government is committed to investing more funds into medical research to help the people of Western Australia. This bill is about making systems and processes easier and better for researchers and, eventually, for medical research.

During my recent visit to the Harry Perkins Institute of Medical Research, I was told a story. I was very keen to know what its model was. The model was a mesh that would eventually replace a bone. A 28-year-old patient in Melbourne had contracted osteomyelitis. The bone infection in his leg had completely eaten up a big portion of the bone and the doctors decided that he needed to have an above-knee amputation. This patient made a request to the orthopaedic surgeon about whether there was any way his leg could be saved for him to be able to walk. He said he was willing to sign any paperwork to give consent for the orthopaedic surgeon to trial something on him. The orthopaedic surgeon then put a mesh there and inserted implants of bone harvested from elsewhere in the patient's body, and eventually that mesh facilitated the bone growth and the patient was able to walk on his own legs. Being able to avoid an above-knee amputation was a big win for that patient. Seeing that mesh was an eye-opener for me because it is not solely medical practitioners or specialists who conduct medical research. Biomedical engineers and engineers specialising in nanotechnology are needed. It is about not only how strong the mesh is, but also how long the mesh lasts so it does not have to keep being replaced in the patient. Medical research is complex and requires multi-speciality and multidisciplinary inputs to be successful and sustainable.

To give some background to this bill, in 2018, following legal advice about involving incapacitated candidates in medical research, public hospitals generally discontinued medical research. Ongoing legal advice was provided to the limited research that was still going on, on a case-by-case basis. Few people continued because it was thought that it was overly complex and people did not want to break the law. As we all know, when COVID hit, the entire world jumped into research to find a quick solution. Be it treating a patient, vaccines, reducing the duration of stays in hospital or preventing death, there was a need for medical research to be very, very expeditiously done to find some solutions for a global pandemic. That is when our government introduced the Guardianship and Administration Amendment (Medical Research) Bill 2020. There were two aspects to it. The consent of a substitute decision-maker was one and urgent medical research without consent was the other. The opposition argued that urgent medical research without consent should have a sunset clause, and eventually a sunset clause was included, which will come into effect on 8 April 2024. If we do not take action to allow research to continue, urgent medical research cannot be conducted beyond that date. In principle, the bill has two legislative recommendations. The first is expanding the definition of "lead researcher" from "medical practitioner" to "registered health practitioner" and the second is repealing the sunset clause. These are the two in-principle changes this bill recommends.

The amendment bill also provides for a statutory review of the operation and effectiveness of various clauses for urgent research. Following its passage, the house took the unusual step of referring the bill and the resulting act for review by the Standing Committee on Legislation. The standing committee made seven recommendations on 25 November 2020, the majority of which were about the changes to be made for the future. The statutory review considered the requirement to obtain a determination from an independent medical practitioner, which was one of the sections. The statutory review considered the current prohibition on electroconvulsive therapy under section 110ZT. These were the two key recommendations of the seven that were taken into consideration.

The Department of Justice took up a review of this whole process, and the first review of the amendments was done in 2022. The subsequent report made five recommendations. The first recommendation was to amend the words "medical practitioner" to "registered health practitioner". The second recommendation was about the definition of "independent medical practitioner". The third recommendation was for the Department of Health to consider amending its medical research decision forms. The fourth recommendation was about the sunset clause. The fifth recommendation was about recommending that the prohibition of electroconvulsive therapy remain in place. There was consultation with the Research and Innovation Office within the Department of Health. The Department of Justice consulted very widely to assess the practical operation and effectiveness of the policy underpinning the legislation. There was wide consultation across the community, including with organisations in the field of disability advocacy; mental health advocacy; First Nations health advocacy; culturally and linguistically diverse health advocacy; and with medical researchers and practitioners, including public and private emergency consultants. After extensive consultation, these recommendations were made.

Case studies of clinical trials were provided during the review. I would like to share a couple of them. The National Health and Medical Research Council funded a study called EXACT. The study was about the fact that when a cardiac arrest happens, a cardiopulmonary resuscitation is initiated as soon as possible. The primary purpose of doing the CPR as soon as possible without wasting much time is to minimise the amount of time the brain does not receive oxygen. Chest compressions are used to manually push blood to the brain because the chest is not pumping; it has come to an arrest and stopped pumping. This EXACT study looked at cardiac arrests happening outside of clinical settings. One measurement the study wanted when this happened was to compare a group of people who had an oxygen saturation of 100 per cent with a group that had an oxygen saturation of less than 92 per cent and see whether the current oxygen therapy protocols made a difference in these two groups and whether there was a requirement to change the protocols to bring about better outcomes. This study cannot be conducted in WA but it can be done in Victoria and South Australia simply because the practical reality is that most of the time when a cardiac arrest happens outside a clinical setting, a paramedic is with the patient, and if the legislation requires a medical practitioner to take up research, the paramedic is unable to do it, which stalls the progress of the research, preventing us from making new findings and better protocols to make things better for patients. Sometimes we go beyond science to try our best in emergency situations, and the clinical judgement should be left to the registered health practitioner rather than there being an insistence that a medical practitioner always take the lead in all research projects.

This reminds me of a record that was broken by a friend of mine, Dr Rao Akula. He was a GP in Kambalda. A physician on a rural visit was driving through Kambalda, walked into his practice and collapsed. This friend of mine tried to revive that physician by doing CPR. Normally, after a period of time people give up, but Dr Rao did not give up and continued CPR for 45 minutes. That happens to be the record for the longest time CPR has been performed in Western Australia. The then Governor-General recognised this by presenting Dr Rao with an award.

Medical research keeps evolving and changing. The important thing for us is to support it, encourage it and make the processes easier and smoother for people who want to take up medical research. Another case study was submitted by the deputy vice-chancellor of research at Curtin University. His team conducted research on patients with dementia living in their own homes. As a medical practitioner, I have treated many patients with dementia, and every GP meticulously conducts annual health assessments on anyone over the age of 75 years. We go through a lot of processes, including whether they are sleeping well; whether they have depression; whether they are able to see, hear and feel things well; their stability and mobility; their ability to manage finances; and whether they are continent. However, we do not know about mobility devices. Despite having been a GP for 25 years, I actually had to ask the physiotherapist how to use a mobility device for my mum, because I am not knowledgeable in that area.

That research team at Curtin conducted research on dementia patients living in their own homes. It makes no sense for a medical practitioner to be involved in teaching a patient how to use a mobility device, but it makes perfect sense for a physiotherapist to do so. Forcing this research team to be led by a medical practitioner will only hamper things and will not facilitate anything. Those are two case studies that clearly state that there is no necessity to restrict research team leaders to medical practitioners; instead, it could be a registered health practitioner.

There is clear evidence that the amount of research being taken up in WA is increasing. It is too early to make a call, but in comparison with 2020–21, when only nine individuals registered or enrolled in this medical research, in 2021–22 that number increased to 115, which is a 13-fold increase in the space of a year. That clearly shows the demand for research, and clearly warrants making the systems and processes more user-friendly to encourage researchers to do more research in support of future generations. I commend the Guardianship and Administration Amendment (Medical Research) Bill 2023 to the house. Thank you for the opportunity, Madam Acting Speaker.

MR D.A.E. SCAIFE (Cockburn) [1.13 pm]: I rise this afternoon to make a contribution to the second reading debate on the Guardianship and Administration Amendment (Medical Research) Bill 2023. I want to acknowledge the member for Riverton, the Parliamentary Secretary to the Minister for Finance. He is a hard act to follow when it comes to health and medicine-related topics, given his long history in the medical profession. I was recently, albeit fairly briefly, on a Speaker's delegation with the member for Riverton during which I got to see just how incredible the life he has led really is. He has gone from a relatively poor rural community in Tamil Nadu in India through to being a GP in local communities in the UK and Australia, and now a member of Parliament in this place. I could not possibly comprehend, let alone match, his breadth of experience in health and medical topics, so I listened intently to his contribution just now.

I will just note in that regard that, unfortunately, the reception I get when I go home to Australind is not the same as the member for Riverton gets when he goes back to his home town in Tamil Nadu! Everyone in the delegation was quite amazed to see firecrackers being let off on the road as we arrived. A crowd formed and came down and there was singing and dancing. Perhaps my favourite part was the two-metre high corflute placards that had been

set up on the roadside and outside various buildings. These included large portrait photos of Madam Speaker, the member for Riverton, the member for Cottesloe and me!

Mr R.R. Whitby: Did you bring them back for the election campaign?

Mr D.A.E. SCAIFE: I should have, minister! I did get a few videos and snaps of it to show my electorate office staff what I expected on my return to Cockburn, but unfortunately that was not the reception I got; I do not think that they think I am deserving of that!

Setting aside the lightheartedness, it is understandable that the member for Riverton receives that sort of welcome in his former community because his story really is an incredible story of someone who came from very ordinary circumstances in a community from which it would really have been unthinkable to aspire to becoming a member of Parliament, and yet he is a member of Parliament, and in another country at that.

Returning to the bill, the main topic I want to touch on is the importance of high-quality medical research for improving our public and private health systems. We really cannot underestimate the importance of that medical research. We are very fortunate here in Western Australia to have some world-leading institutions, such as the Telethon Kids Institute and the Lions Eye Institute. We have been drivers and beneficiaries of great medical research here in Western Australia, and it is important that we continue to support our medical research industry and academics.

The nature of medical research is that occasionally the research is conducted in circumstances in which someone might be incapacitated. That is just the nature of medical research—that someone may be experiencing a very significant health episode at the time that the research needs to be carried out, or at the time novel treatments need to be tested. As the member for Riverton mentioned, that is where this bill originally comes from. We have been undertaking medical research in our public hospitals for many years, including in circumstances in which people may be unable to make decisions for themselves, but we discontinued that research in 2018 after being provided with legal advice that that research probably was not authorised by the Guardianship and Administration Act 1990.

Then, of course, the COVID-19 pandemic came about and created a circumstance in which we were dealing with a novel virus. We were trying to not only rapidly develop new treatments, but also test whether existing treatments, such as antiviral treatments, would work. There was a sudden urgent need to provide care—in some cases, novel and untested care—to people who were incapacitated by the coronavirus. That resulted in the government introducing the Guardianship and Administration Amendment (Medical Research) Bill 2020, which allowed for medical research to be carried out on people who may have lost consciousness or been incapacitated. Certain conditions were placed upon it.

This bill addresses two recommendations from a legislative review conducted by the Department of Justice; first, to change the definition of “lead researcher” by deleting “medical practitioner” and inserting “registered health practitioner”; and, second, to repeal a sunset clause that was placed on the legislation when the amendment bill was originally considered. The reason it is important to repeal the sunset clause and ensure that we have a regime for medical research for people who may not be able to provide consent has been adequately highlighted by the circumstances of the COVID pandemic.

I want to focus a little on why good-quality randomised research in our medical profession is so important. Generally, Australia is not particularly good—I say this about most countries—at carrying out randomised control trials of public policy interventions, whereas in science and medical science, randomised control trials are considered the gold standard. In such trials, people are randomly allocated to a control group or a treatment group, rather than having a self-selecting audience. Over time, researchers can see the effects that the treatment has on the treatment group and how that compares with the control group, and can draw much firmer conclusions about whether the treatment works and whether it has any unintended consequences. We are generally quite bad at that in public policy but generally very good at it in science, particularly in medical science. We need to carry out those sorts of randomised control trials in public policy generally, but people often raise ethical objections to such trials. They say, “Surely if you pick one group of people to be exposed to a trial of a welfare program over another group of people, parts of the community are potentially disadvantaged. That means that one person gets the benefit and one person misses out, which raises an ethical issue.” The truth is that that can equally be said about randomised control trials for medical research. One person may be allocated. The example that the member for Riverton referred to involved one group of people who were monitored at 92 per cent blood oxygen saturation and another group that had 100 per cent blood oxygen saturation. Those people were treated differently. The reason they were treated differently was that, provided there was a level of safety and certainty around those different treatment groups and we were not causing harm to the treatment groups, we wanted to find out what made a difference. Does 100 per cent blood oxygen saturation make more of a difference than 92 per cent blood oxygen saturation?

I recently came across a different case study from the one mentioned by the member for Riverton—the head injury retrieval trial. It was set up in New South Wales over 10 years ago to answer some questions relating to people who had experienced head injuries. The questions asked were: Would it make a difference if a victim with a serious

injury was treated at the scene by a physician as opposed to being treated by a paramedic? Can we justify the additional cost of sending a physician out to a person who has experienced a head injury as opposed to sending out a paramedic? When a Sydney 000 operator received a report of a serious head injury, effectively they tossed a coin: one person would get an ambulance and a paramedic; the other person would get a helicopter and a trauma physician. From 500 cases dealt with like that, the researchers effectively created two groups of patients randomly allocated to treatment from a paramedic or treatment from a physician, and then compared the results. I wish to quote an article by Dr Andrew Leigh. I do not believe that he was a member of Parliament at the time, but these days he is the federal member for Fenner in the ACT and Assistant Minister for Competition, Charities and Treasury. Dr Leigh said —

When writing an article about the trial last year, I spoke with Alan Garner, who told me that, although he has spent over a decade working on it, even he does not know what to expect from the results ... ‘We think this will work’, he told me in a phone conversation, ‘but so far, we’ve only got data from cohort studies.’ Indeed, he even said, ‘Like any medical intervention, there is even a possibility that sending a doctor will make things worse. I don’t think that’s the case, but [until HIRT ends] I don’t have good evidence either way.’

An experienced medical physician and researcher was saying, “I think it’s best to send a trauma physician to a serious head injury but I can’t be sure about it and I don’t know, despite all my years of experience, exactly how much of a difference it would make and I don’t know whether or not the cost to the taxpayer of sending the trauma physician is worth the benefit that may or may not be experienced by the person who has been in the accident.” I thought that was a really innovative example of a medical research trial that dealt with some of those difficult ethical issues. It is also exactly the type of study that may be affected by this bill. We can imagine that somebody who has suffered a serious head injury would most likely be incapacitated or at least have significantly impaired cognitive ability, whether from shock or the injury itself. Those people may be unable to consent to participate in medical research.

In Western Australia, as the law stood before 2020, we would not be able to undertake research like the head injury retrieval trial. If the sunset clause remains in the legislation, we will not be able to undertake that research when the sunset clause takes effect on 8 April 2024. We have under a year until the sunset clause takes effect and we would no longer be able to carry out research like the head injury retrieval trial, which would be a real shame because that sort of research can result in better public policy, savings for the taxpayer and, most importantly, better medical treatment for people who desperately need it. I really welcome that change.

The second change, which I mentioned earlier, is the expansion of the definition of “lead researcher”—the person authorised to conduct research involving someone who might not be able to consent—from medical practitioner to a registered health practitioner. The member for Riverton mentioned a case study involving physiotherapists at Curtin University who had been working with people experiencing dementia and training them in how to use a walker after they had had a significant fall or if they were experiencing significant balance and mobility issues. The researchers in that case would ordinarily be physiotherapists or occupational therapists and a medical professional would not be required, but because the act says that the lead researcher must be a medical practitioner, they had to bring in a medical practitioner to oversee the research. That was not really necessary and the medical practitioner did not necessarily have the expertise that people like physiotherapists, occupational therapists and other allied health professionals might have in their respective fields.

This change seems very sensible to me. We know that many of our allied health professionals do important and significant work that requires significant expertise, so I think it is appropriate that those other registered health practitioners be given an opportunity to lead research within their own field and not necessarily have to call in oversight from a medical practitioner, who might be very well respected and well experienced but might not have the expertise that is needed.

[Member’s time extended.]

Visitors — Ashdale Primary School

The ACTING SPEAKER (Ms M.M. Quirk): I will just interrupt and welcome the students from Ashdale Primary School who are up in the gallery today; they are my great friends. Welcome, everyone. You are hearing some great wisdom from the member for Cockburn.

Mr D.A.E. SCAIFE: I think the Acting Speaker might be stretching the description of my contribution, but I appreciate it. I, too, welcome the students from Ashdale Primary School. It is great to have you here. You will see the parliamentary process play out in real time.

Debate Resumed

Mr D.A.E. SCAIFE: The last thing I want to do is to acknowledge some people who work in the medical research field whom I am very fortunate to know. I recognise Professor Yogi Yogesan and Professor Warren Harding, AM,

Extract from Hansard

[ASSEMBLY — Wednesday, 21 June 2023]

p3161b-3168a

Dr Jags Krishnan; Mr David Scaife; Mr Shane Love; Ms Meredith Hammat

who are involved in a company could Medivitals. This really exciting local company has been developing software, predominantly, that can be used to remotely measure and monitor someone's vital signs and, through the use of artificial intelligence, alert someone if there is something to be concerned about. We can imagine the different settings in which this could be used. For instance, it could be used in a hospital emergency department waiting room when someone is being triaged. The patient might need to wait an hour and so. If they were wearing this device that tracks various vital signs, like blood pressure, pulse and blood oxygen saturation, the device could alert the triage nurse, for example, if they deteriorated and needed further attention and assessment. It is a really great piece of technology. It is a great example of local innovation in medical research. I have been very fortunate to speak with both Professor Yogesan and Professor Harding about that research and I wish them the best. I know they previously received innovation grants from the state government to support their work. I certainly wish them the very best with their research and the commercialisation stage.

I also take this opportunity to congratulate Professor Harding on being awarded a Member of the Order of Australia in the King's Birthday honours list. Professor Harding was recognised for the variety of ways in which he contributes to the local community. I do not have the precise citation in front of me, but knowing Warren, I can say that he is a hardworking and enterprising individual with great values. I know that his contribution to medical research was one area for which he was acknowledged through the awarding of the Member of the Order of Australia. Congratulations to Warren, and best of luck to both Warren and Yogi as they continue to develop Medivitals.

That brings me to the conclusion of my contribution. I reiterate that this seems to be really sensible legislation that will essentially take us back to the assumed position before 2018. This legislation follows reviews by both a standing committee of the upper house and the Department of Justice. The bill will make sensible changes that will make it easier for medical research to be undertaken. It will ensure that people who are incapacitated—who have lost consciousness—can receive potentially lifesaving treatment in scenarios in which there is uncertainty about what they are suffering from or how to treat them, as we saw during the COVID-19 pandemic. I welcome the bill. I think it should be endorsed by members of the chamber, as it was by members of the other place. We saw the emergency legislation in action during the COVID pandemic. It is now time, after the reviews, to lift the sunset clause and expand the definition of "medical practitioner". I commend the bill to the house.

MR R.S. LOVE (Moore — Leader of the Opposition) [1.36 pm]: In front of this rather packed audience, I rise to make a contribution on this very important although somewhat brief bill. The Guardianship and Administration Amendment (Medical Research) Bill 2023 is quite a simple document as far as bills go. It is eight clauses in length and has two main thrusts. Although it might be a small document, I am sure that members will appreciate that there has been a great deal of consideration over a number of years of the very important ethical and moral considerations behind what is being advanced in this bill. We should not just dismiss this as being a small matter, given the extremely sensitive nature of the things that are being discussed in the bill.

I thank the member for Cockburn and other members of the house who have made contributions on this bill. I point out that the bill was originally introduced in the Legislative Council on 22 February, so it has been through the Legislative Council's processes. It was supported by the opposition in that chamber, as it will be in this chamber. It arrived in our chamber on 23 March, a month after its introduction in the Legislative Council. The Attorney General read in this bill. As I said, we know that the thrust of the bill is important. The bill will advance the interests of the medical research community by amending the Guardianship and Administration Act 1990 and the Guardianship and Administration Amendment (Medical Research) Act 2020 by making two changes governing the participation of incapacitated represented persons in medical research programs, including where it might be urgent research. It will do this in a couple of ways. First, the bill will expand the definition of "lead researcher". Previously, the lead researcher could be only a medical practitioner. This bill will expand the definition to include the 16 occupations listed under the Health Practitioner Regulation National Law (WA) Act, such as nursing and physiotherapy. A wider range of people will be able to participate in medical research. It recognises in that, I think, that not all research is conducted in some sort of hospital environment. It can be done through studying people in their community or while they are still living in their homes, over a wide range of circumstances. This will allow a wider range of circumstances to apply and be captured under those acts that we have spoken of.

It will also remove the sunset clauses from the 2020 amendment act, which would have come into effect on 8 April next year. Without them, we would have needed transitional provisions, which will also be deleted from that act. For the advice of the Attorney General and his advisers, I will not be seeking to go into consideration in detail on this bill. The issues have been well discussed in the other place and through a judicial review. The Standing Committee on Legislation conducted an inquiry into these matters and released a report in November 2020. I believe the judicial review was released on the same day that the bill was introduced to the Legislative Council. It might have even been the day before. I think it was released on 21 February and then tabled. There has been a lot of information out there and a lot of discussion. Although the ramifications of what we are talking about are quite extensive and sensitive, I think there has been sufficient explanation of them both in the discussions in the other

place and also in the second reading speech by the Attorney General and the information provided to the house in the explanatory memorandum.

We will not necessarily be going to the consideration in detail stage, although it is entirely possible that a person from the government may wish to interrogate the Attorney General, but the opposition will not be calling for it in this case.

Several members interjected.

The ACTING SPEAKER (Ms M.M. Quirk): Members for Butler and Mount Lawley, just sotto voce, please.

Mr R.S. LOVE: Sorry.

The ACTING SPEAKER: Do not apologise. It is not your fault, Leader of the Opposition.

Mr R.S. LOVE: I did not want to forestall some contribution from the member for Mount Lawley. We are all looking forward to his contribution, though we might not get to it before question time. Maybe we will. I think we will. Anyway, I will get back to the legislation.

The ACTING SPEAKER: I think the member for Mirrabooka is next.

Mr R.S. LOVE: The 2020 amendment bill was debated at that time when the COVID temporary orders were in place; I believe that was one of those bills that was debated under those circumstances. The then Minister for Health introduced it and in his second reading speech he said —

The Guardianship and Administration Amendment (Medical Research) Bill 2020 provides critical legislative amendments that will enable our doctors to join the global effort to trial new and emerging treatments for COVID-19.

...

Last week, members would have heard Dr Andrew Miller, the —

Then —

president of the Australian Medical Association Western Australia, state that if Parliament does not pass amendments to the Guardianship and Administration Act 1990, our doctors and hospitals cannot offer all Western Australian COVID-19 patients a chance to benefit from the trial therapies that are being used around the world.

That was part of the discussion back then. If members cast their mind back, they will remember that it was a different time, when people were interested in not only treatments, but also the effect various treatments might have, and varying treatments might have as well. Imperatives were probably in people's mind at that time, but the origins of the bill commenced before that, in 2018. A health directive had brought about an end to the ability for incapacitated persons to be enrolled in medical research as distinct from medical treatment. That is where the issue arose. Until then, the two issues were not separated, as I understand it, but from 2018 that separation had begun. There was a need to alter that. I understand that the research community was advised at that stage by the Attorney General and the Minister for Health that a new law would be drafted so that this could be addressed.

We know that there is a bit of history around this. As I have said, there was a lot of discussion around these matters back in 2020, when the sunset clauses were first introduced. We are now aware that those matters are not necessary because the reviews that took place and the experience of the last two years or so have allowed us to understand the effects of those provisions and to feel that there is some comfort that sufficient safeguards are in place before any research can take place.

I go back to the fact that the bill has only eight clauses. The issues are much greater than eight clauses might suggest. We are dealing with people who are incapacitated and are being enrolled in research when they are not able to give their own consent, so it is a sensitive area.

With that, I will conclude my contribution because I know that other members want to make a contribution on this legislation. I reiterate that the opposition has supported this legislation in the Legislative Council and we will continue to support it for the rest of the debate in this chamber.

MS M.J. HAMMAT (Mirrabooka — Parliamentary Secretary) [1.46 pm]: I also rise to make a brief contribution on the bill before the house, the Guardianship and Administration Amendment (Medical Research) Bill 2023. Speakers before me have covered some of the points that I will also cover, but I think it is an important bill. In preparing my comments today, I could not help but revisit that time in 2020 when the provisions that we are now amending were passed by Parliament. We were dealing with a range of things right in the very beginning stages of the COVID pandemic. It is easy to forget the context of the time, so in preparing these comments today, I revisited that time in 2020. I was not in this Parliament then, but I was in a role in which we had concern for what might happen to working people and how work might be impacted at a range of different levels.

Not only in Western Australia but clearly all around the world, we saw a set of circumstances that we had never seen before in our lifetime. They were very rapidly changing circumstances as we saw the pandemic move through different countries around the world. It was a time of enormous uncertainty and almost incredulousness; people were struggling to come to terms with what was happening before their eyes. As a community and more specifically, those in decision-making roles in Parliament, we collectively turned our minds towards what we would need to think about to respond to this rapidly emerging global crisis, in not only economic terms, but also health terms, social terms and a range of different ways. It was a very unusual period. In that context, this Parliament turned its mind to implementing provisions that would ensure that if people were not in a position to provide consent, there would still be some opportunity for emerging medical treatments to be used. Of course, it was really a situation in which people—the medical profession, but people generally—were looking for ways to slow down the progress of the coronavirus if people were infected and provide opportunities to recover.

The development of vaccines at the time was seen as something that would take many, many years to achieve. Our history of medical research told us that it was not easy to find a vaccine that would be a cure, so people were grappling with the idea that we could not protect ourselves from coronavirus for many years. As it turns out, vaccines progressed more quickly than people anticipated, and that has given us a degree of protection and allowed life to return mostly to normal as we stand here in 2023. However, none of that was known at the time. In fact, I recall vividly—I am sure many people in this place do as well—that every day we would get up to read the news to find out what had happened around the world overnight and the emerging stories and situations. People in WA and around Australia will recall being transfixed by news reports to understand what was happening, what was the latest information and how people could respond to protect themselves and their families. It was an unusual period, and this Parliament, the government and organisations took a range of unusual steps in that context, because it was absolutely necessary to do what we could to protect the population and the economy. There is no doubt that history will show that Western Australia came through that period better than many other places around the world. That is part of the legacy of not only former Premier McGowan’s leadership, but also the collective leadership of the cabinet and this Labor government.

The bill that comes before us today has seen a number of periods of review. The clauses inserted in 2020 had been subject to a statutory review of the 1990 act in 2015. Subsequent reviews occurred. As the amendment was passed through Parliament, a sunset clause was inserted into the amendment act that basically meant a repeal would be effective on 8 April 2024. The amendment also provided for a statutory review of the operation and effectiveness of part 9E, which deals with medical research—specifically, the section that deals with urgent research. A committee reported on the operation of the legislation, and a review was undertaken by the Department of Justice as well, so there has been extensive work undertaken to review the operation of these provisions. Extensive consultation was a part of that process as well to ensure that we found a way through this complex and difficult set of circumstances.

It is interesting to reflect on the decisions and choices that people make as they confront illness, and perhaps serious illnesses that might lead to death. That was the context in which we considered COVID—the fact that it could quite likely cause the death of people who had contracted it. In a number of areas, there is ongoing research into cures and novel treatments that might slow the progress of diseases. If anyone has had a loved one who has had the opportunity to use a treatment that is still being tested, and if the alternative to that has been a quickly degenerating disease and certain death, they will know that people are often very open to exploring other avenues to find a treatment or lengthen their life. People suffering from cancer often have opportunities to use experimental drugs or other things. People are very willing to embrace these kinds of opportunities for lengthening their life and slowing the progress of that disease.

I am mindful that we often reflect on a range of different diseases in this place. I think today we are recognising research into motor neurone disease. We recognise a range of different illnesses in this place by wearing pins or a particular colour as a way of raising awareness. Parliamentary friendship groups are also very active in raising awareness around incurable diseases and other things. Awareness raising is a really important part of getting people to embrace making donations and financial contributions to allow the very important groups in this space to continue their good work. This work is often based on finding drugs, cures, treatments and various other things, so we need a legislative framework that supports the good work undertaken by a variety of different groups to raise people’s general awareness about many different diseases.

I use this opportunity to give a shout-out to the people who are supporting us today with motor neurone disease awareness. For those who might later watch this on video, I have not put on the blue cornflower, but others will be wearing them in aid of raising awareness about motor neurone disease.

I will make a few other brief comments before I conclude my contribution. Others before me have talked about the important work that is being done in the field of medical research. I acknowledge a number of very important and valuable research institutions here in Western Australia that are conducting important work. I join my colleagues in recognising that work. It is really important to underline the excellent work that goes into medical research. It often takes many years—more patience than I would have—to conduct the sort of experiments and research that uncovers cures and treatments. Again, I come back to the early stages of the COVID pandemic, which was the

genesis of this bill. People might recall there was a lot of speculation about possible cures or treatments that might be accessed to help them either avoid COVID altogether or slow its progress.

I am grateful to Princeton University for doing some work to compile what it called the disinformation that was being distributed about possible COVID cures and treatments at the time. Some people may recall bogus treatments were being promoted by people in very senior leadership positions in other countries, who perhaps should have known better.

Mr S.A. Millman: Like the President of the United States.

Ms M.J. HAMMAT: Yes. The member for Mount Lawley mentions the then President of the United States.

Mr S.A. Millman: It was very unhelpful.

Ms M.J. HAMMAT: That is exactly right: they were very unhelpful contributions from that president, who was producing misinformation.

In Fiji, pure vodka was put forward as a cure. One might think that is a remedy for a range of different ills, but that was something peddled in Fiji. In Egypt, it was dried fish. The report is not clear about how dried fish should be used to prevent or cure COVID, but presumably it was by eating it. More than 243 distinct storylines were identified about false cures, preventive measures and diagnostic procedures—243 different ideas that were being peddled about ways that people could treat coronavirus. That is a really good illustration that there were a lot of different views around at the time. Sadly, some of those were peddled to profit off people who were scared, worried or perhaps naive, but people were clearly selling bogus cures and making really exaggerated claims. It was quite common during the pandemic to hear ideas about old drugs having new uses. That was clearly one of the things that was favoured by then President Trump, who looked at a whole range of different things, including antimalarial medications, that were proposed to be able to assist in the treatment of COVID.

Debate interrupted, pursuant to standing orders.

[Continued on page 3185.]