GUARDIANSHIP AND ADMINISTRATION AMENDMENT (MEDICAL RESEARCH) BILL 2023

Committee

Resumed from an earlier stage of the sitting. The Chair of Committees (Hon Martin Aldridge**)** in the chair; Hon Stephen Dawson (Minister for Emergency Services), on behalf of the Parliamentary Secretary to the Attorney General, in charge of the bill.

Clause 1: Short title —

Committee was interrupted after the clause had been partly considered.

Hon STEPHEN DAWSON: In relation to the question asked before the break, it will be the clinician's responsibility to ask patients or their guardian or next of kin if they have an advance health directive. If they do, the clinician will ensure it is registered in WebPAS. If the patient or guardian does not disclose that an AHD is in place, or if the clinician does not ask whether an AHD is in place, usual consent processes will apply.

The AHD was expanded six months ago to include a section pertaining to a patient's wishes in relation to participating in research. Any questions relating to the validity of an AHD will be a matter for the State Administrative Tribunal. If there are any complaints regarding consent to research, usual complaint processes will apply. Complaints will be able to be raised to the health service executive through a variety of reporting mechanisms, some of which do not differentiate between complaints related to clinical care, and complaints related to participation in research. It is therefore impossible to accurately quantify how many complaints have arisen from represented persons' participation in medical research.

In response to a question by Hon Nick Goiran, I am advised that the Mental Health Law Centre WA and Ruah Community Services support the current prohibition on electroconvulsive therapy.

Hon TJORN SIBMA: Thank you, minister, for that answer. I will first ask what I think is the easier question and then get to the next one. Of the incapacitated persons who have presented at a hospital, have been treated and have subsequently been enrolled in a medical research program of some kind, what proportion of them did not have an advance health directive at the time of their admission?

Hon STEPHEN DAWSON: We do not have that information. The patient has to provide that information. It is a voluntary system. We do not have that information.

Hon TJORN SIBMA: I might leave that dimension aside. That is fine. However, the minister mentioned that six months ago, a field was added to the pro forma of an advance health directive that more directly asked to indicate somebody's preference or inclination to participate in medical research. If I heard that correctly, that is a welcome development. I would like to inquire a bit more into that, please. It was clear around September or October 2020 when the standing committee inquired into the act—the review happened subsequent to the passage of the bill—that the proportion of individuals enrolled in COVID-related treatments at that point could not be quantified. One of the reasons was that the relevant statutory forms at that stage, around October 2020, had not yet been drafted. I say this because my next tranche of questions relates, in whole or at least in part, to these statutory forms. Perhaps they could be obtained for me during the dinner adjournment; we will go at least that far. How many statutory forms are currently utilised in the enrolment of incapacitated persons in medical research in Western Australia? Might the pro forma of the forms potentially be tabled?

Hon STEPHEN DAWSON: There are two forms, honourable member. There is one for urgent and one for non-urgent. I am told that the Standing Committee on Legislation attached the forms to its report in appendix 5. I am not sure whether the member has that report handy. If he does not, I was going to say I could get a copy a little later on.

Hon TJORN SIBMA: Yes, I do. Has there been any alteration to the presentation of those forms in the three years that they have been operative? Are any intended changes to those forms likely to emanate from the passage of this bill this evening?

Hon STEPHEN DAWSON: I am told that a typographical error was fixed. As part of the review of the act undertaken by the Department of Justice, a recommendation was made that the Department of Health, in consultation with key stakeholders, consider amending its "GAA Medical Research Decision Form" for urgent treatment to include a field whereby the research decision-maker's name and the capacity in which they are providing their consent is recorded on the form. That change was made. I am further told that, regarding the previous question, item 2 on the form relates to advance health directives. It is under the researcher declaration that reads —

> I am not aware of, and would not reasonably be expected to be aware of, any current advance health directive that is inconsistent with this research.

Hon TJORN SIBMA: Since we are on forms related to the safeguard provisions, post the enrolment in a medical research program of some kind, what happens to the completed forms? Where are they sent?

Hon STEPHEN DAWSON: I am told that the forms are ultimately sent to the Department of Health. The research may well start off with the HSPs, then the forms are sent to the health department.

Hon TJORN SIBMA: Just going back a bit, concerning the change to the "GAA Medical Research Decision Form" for urgent treatment, I think a field concerning the research decision-maker was recently updated. Was that the appropriate form?

Hon STEPHEN DAWSON: I am told that that suggested change is in the process of being made.

Hon TJORN SIBMA: Forgive me my obsession with these pieces of minutiae, but will that change be reflected in both forms or just the singular form concerning the urgent treatment of incapacitated people?

Hon STEPHEN DAWSON: I am told that it will be updated once the act is passed. The recommendation from the Department of Justice related only to the urgent form.

Hon TJORN SIBMA: If I understand correctly, the recommendation was in respect of only the urgent form. Nevertheless, post the passage of this legislation, will it be reflected in both or will it be just the urgent form?

Hon STEPHEN DAWSON: I am told that the requirements are to reflect it only in the urgent form, but I am further told by people at the table that they think it will be reflected in both forms.

Hon TJORN SIBMA: I think that is quite an encouraging development. I will not make this a withering criticism but there is some grizzling, which is reflected in the final report on behalf of researchers. Again, that is not a personal reflection but an expression of frustration with the administrative process. I might get to that in due course, but there was quite a considerable degree of focus in the recent review on the role of the independent medical practitioner, which I thought at the time was, to the degree that such terminology is used a bit loosely, a reasonable safeguard for inclusion. I have a series of questions about this matter. I am almost 100 per cent sure that I will find myself in violent agreement with the government, but I want to absolutely understand; it is no doubt encouraging for the government to hear that.

Hon Sue Ellery: We are thrilled.

Hon Stephen Dawson: We do not get many compliments, honourable member, so we will take that.

Hon TJORN SIBMA: You may not get many; I get absolutely none! But I am here for the thrill of it alone.

Hon Sue Ellery: It is character-building.

Hon TJORN SIBMA: Isn't it just!

Hon Stephen Dawson: You should get a pastime!

Hon TJORN SIBMA: Unfortunately, given our streamlined representation in both chambers the opportunity for pastimes has slipped me by for the last two years and will slip me by for at least the next two.

Hon Stephen Dawson: Not in the Legislative Assembly it isn't.

Hon TJORN SIBMA: I am absolutely focused. This is all highly amusing and interesting to everybody else, I am sure!

I want to interrogate this a little bit. At pages 25 to 27 the matter of the independent medical practitioner is raised, presumably because a class of stakeholders, being the medical researchers, considered the definition to be unclear and said that it should be improved. I will read this quote from the North Metropolitan Health Service and Australian and New Zealand Intensive Care Society's submission of 22 February last year —

> [In] *the acute care setting (eg Intensive Care, Emergency Department), the treating doctor (not the IMP) best knows the patient's acute medical condition that causes incapacity and the likely duration of the incapacity. Furthermore, the treating doctors in the critical care setting generally know the patient's wishes better than an IMP who had no current contact with the patient and the next of kin.*

Further, the Harry Perkins Institute and Centre for Clinical Research in Emergency Medicine say in submission 3 received by the review —

> *The definition of IMP has confused some doctors when they are asked to declare that "I am not currently involved in the treatment of the research candidate which is related to the research." … Asking for a doctor not involved in the treatment of the patient appears counter-intuitive and time intensive.*

Furthermore, the Australian College of Emergency Medicine said —

> *The definition of the Independent Medical Practitioner does not recognise the research that is undertaken by other AHPRA registered health professionals such as nurses, psychologists, paramedics and other allied health professionals. The terminology for the IMP should be changed to Independent Health Practitioner.*

I attempted on a number of occasions to get to the nub of their concerns, and I am still struggling to understand what the key issue is. Is the matter definitional and could it be easily remedied in a way that does not undermine any existing safeguard of the bill or is this just the way that the stakeholders have expressed some frustration with having to go through—I will put it in a pejorative way—a bureaucratic process to ensure that they are operating within the bounds of the law? I am perplexed by the fixation on this matter and I want to invite the government to explain the concern to me and why the government is effectively proposing not to make any change.

Hon STEPHEN DAWSON: I think there were probably a couple of things in that contribution. I am advised that there is no prohibition on the independent medical practitioner being the candidate's usual treating doctor. So, that is there. I am told further, pejoratively, they are not lawyers, so there is no prohibition on this.

In relation to the member's question about the other submissions about who can be an IMP, the advice is that the IMP is a crucial safeguard in the medical research enrolment process and adheres to the principles of the Guardianship and Administration Act, which are to protect vulnerable people. The IMP must assess various matters in relation to the represented person's participation in the research. This process is complex and involves many steps. By extending the role of the IMP to nonmedical health practitioners, there is the potential of the risk assessment that the IMP conducts, which must take into account all the conditions and symptoms particular to the patient, being undertaken by a health practitioner without the appropriate training. The Research Governance Service provides guidance and clarification as well as a definition on what constitutes an IMP.

Hon TJORN SIBMA: We are dealing with a bill that relies upon a catalogue of reviews and reports and we have a proximate report that deals with this matter in a variety of ways. I am just trying to understand why what is in the bill is presented in the bill and why things that might meet the aspirations of stakeholders are not reflected in the bill, seeing as, in the main, this bill more or less enlivens or delivers upon some of the other frustrations that medical researchers have expressed, particularly in regard to the looming sunset clause.

Might there be an argument, minister, that perhaps, if not definitional, complying with the IMP requirement will pose some challenges in a community setting? I read here from a contribution from Silver Chain, which is quoted on page 27 of the review. It states —

> [Silver Chain is] *currently undertaking an evaluation of a new overnight, in-home palliative care respite service in WA. To this end, we commissioned an Australian academic group at the forefront of person-centred palliative care research. Currently, Silver Chain and the research team are grappling with the dilemma of whether to include or exclude incapacitated Research Candidates, due to the logistical challenges of engaging at least two medical practitioners. This has significantly delayed commencement of the project, the outcome of which will inform funder decision-making about future continuation of the service. In addition, if we are unable to include incapacitated clients in this study, we lose the opportunity to contribute knowledge about the potential benefits of in-home palliative care respite for a high risk group and their carers.*

There are a few other questions that come out of this example, but I suppose my basic question is whether Silver Chain has a point in this instance. Is the necessity to obtain an independent medical practitioner certification—for want of a better technical description—an impediment in settings like this and in the treatment of conditions like this?

Hon STEPHEN DAWSON: There are a couple of things there. Expanding the definition of "lead researcher" to Australian Health Practitioner Regulation Agency–registered practitioners will, to an extent, remedy the lack of IMPs in community settings. Secondly, though, as I am sure I said earlier, in the *Review of the Guardianship and Administration Amendment (Medical Research) Act 2020 (WA): Final report*, finding 3 says —

> The Department finds that the safeguard offered by the definition of 'independent medical practitioner' in section 110ZO of the *Guardianship and Administration Act 1990* (WA) has been operating appropriately, despite the fact that some health professionals involved in medical research who are not medical practitioners have been unable to enrol incapacitated persons in their research projects.

Hon TJORN SIBMA: I concur with the assessment at the beginning of the minister's response in that, if I may put it this way, the frustrations with the operation of the act as it relates to Silver Chain and this particular form of in-home palliative care might relate more directly to the definition of "lead researcher" and the range of health practitioners dealt with in clause 4 of the bill rather than the matter concerning the independent medical practitioner. From my very untutored reading of this, finding 3 and recommendation 2 in the report are reasonably sound. What concerned me when I read through this a little further is found on page 29. I may be of a cynical disposition, but I am not ordinarily of a suspicious disposition. I think in this case it is a distinction with a difference. Nevertheless, the East Metropolitan Health Service submitted to the review —

> … that it has implemented several risk-stratified solutions to deal with the 'practical challenges' of the IMP requirements in the Amendment Act:

Again, the IMP requirements are not being amended here —

> *For low-risk projects the researchers identify and train colleagues within their Department. For example, the RPH Emergency Department designate their 'EPIC' (Emergency Physician in Charge) as an on-duty IMP for research projects. However, if the EPIC happens to be an investigator on a specific project, another medical practitioner on the ward must take on the role.*

I make the observation that, in my view, not being a medical practitioner, it is appropriate that there be no opportunity for a conflict of interest for someone who is on duty to use the advantage of that position to enrol subjects in their trial. It goes on —

> *For higher risk interventional and invasive studies, the designated IMP is the EMHS Director of Clinical Services DCS … While this ensures a single contact point, the DCS may be unavailable if attending to other urgent patters, —*

I think it is meant to say "matters" rather than "patters" —

> *potentially delaying or preventing an enrolment.*

Further, these are the words of the drafters of the report —

> EMHS noted that neither of these options are 'ideal' and 'each has strengths and weaknesses.'

Rather than just giving voice to my concern about the best intentions of a bill being interpreted in different ways, the challenges—I call them workarounds—identified in complying with an article of law that is expressed in a way that is frustrating causes me a little bit of concern about how well the IMP provisions have been complied with and whether they might be being either insubstantially or substantially contravened in practice. I hope that is not the case, and I am certainly not making any allegation. But the useful and practical question I can ask at this juncture is: is there a degree of—I will not say flexibility—interpretation and institutional response in the way that different hospitals manage this issue? It seems in this instance that the East Metropolitan Health Service is quite clear that it finds it problematic and is attempting to deal with it. Is that true? Do different hospitals manage compliance with the law in different ways or is there a degree of uniformity at least in the resource dimension of individuals who are capable of fulfilling that function in a way that does not compromise them while on call at any one time?

Hon STEPHEN DAWSON: I am going to answer this in a couple of ways. There is nothing to suggest that the IMP requirements have not been complied with. Some clinicians think that the inclusion of an IMP is perhaps burdensome, and they have made that clear. The member might have received a letter. Certainly, there is a letter floating around about that. It is important to remember that the purpose of the act is to protect vulnerable people. I draw the member's attention to the summary report that was tabled in Parliament on 19 August 2021. It is the most recent report to the minister in relation to research candidates recruited under part 9E, "Medical research", of the Guardianship and Administration Act 1990.

Hon Nick Goiran: That was to the health minister, not the Attorney General.

Hon STEPHEN DAWSON: Yes, it is to the health minister. I beg your pardon; it is actually the second report. It is not the 2021 report; it was tabled in 2022. I quote from page 4 —

> The number of research candidates enrolled under Part 9E has substantially increased in the 2021/22 reporting period … compared to the 2020/21 reporting period … indicating that Part 9E is generally enabling the participation of incapacitated adults in medical research.

The numbers have grown. Each health service provider is able to manage the implementation of the requirement independently so that it best suits its needs, but there is a process that everyone aspires towards to minimise differences.

Hon TJORN SIBMA: I might ask about that ministerial report later. I want to clarify which department we are talking about. Hon Nick Goiran raised a relevant point about which minister was being referred to. The department that completed the final report is obviously the Department of Justice. When references are made to a department acknowledging certain pieces of evidence or arguments provided by submitters, I want to be very clear that I have the right department. In relation to the East Metropolitan Health Service, the example I quoted, the *Review of the Guardianship and Administration Amendment (Medical Research) Act 2020 (WA)* states on page 29 —

> The Department acknowledges the burden that the IMP requirement may impose on medical researchers in certain situations, such as emergency medicine or paramedicine, and in regional, rural or community settings.

Which department's views are articulated in that passage?

Hon STEPHEN DAWSON: It is the Department of Justice. The Department of Justice led the review. It had representatives of the Department of Health and the Office of Medical Research and Innovation, now known as the Research and Innovation Office.

Hon TJORN SIBMA: I have a question out of curiosity—I am not being cute or disrespectful. This document is presented as a report, not as a report for ministerial endorsement. There is a distinction between the kinds of reports that are provided to executive government, as the minister would understand. Some are reports seeking ministerial endorsement, even if the minister's fingerprints are not that distinguishable on the document, and some are just for noting. I make the assumption that this report is just for noting. Can I determine whether other relevant ministers with a stake in this—namely, the Minister for Medical Research and the Minister for Health—also received a copy of this report at the time this bill was introduced?

Hon STEPHEN DAWSON: Certainly other ministers would have got a copy after the report, not a draft, had been finalised. Certainly, I did as Minister for Medical Research and other ministers may well have, too. The report is the report of the Attorney General. The department did the work on behalf of the Attorney General. It is his report. Certainly other ministers may well have got a copy of the final report on the way to cabinet.

Hon TJORN SIBMA: I am therefore going to assume—I think it is a fair assumption—that unless a distinction is made otherwise, and I have not found one, that I can fairly interpret the words "the department acknowledges" as saying that the government acknowledges or notes that there is a uniform perspective on this matter, which is shared across the relevant agency, and not just the perspective of one agency that happens to have the voice.

Hon STEPHEN DAWSON: No, I do not think the honourable member can assume that. The report was undertaken by the Department of Justice on behalf of the Attorney General, so it is Justice's view, as it is written. The report would have gone to cabinet for noting. I do not think the member can say that it is the whole of government view just because we have noted the view of a particular agency.

Hon TJORN SIBMA: This might be a fruitless exercise, but would it be a reasonable assumption for me to hold in relation to the treatment of this issue and the debate on this bill that the Department of Health would share the acknowledgement that the Department of Justice makes in that the independent medical practitioner requirement may impose a burden in certain circumstances?

Hon STEPHEN DAWSON: As I have previously indicated, the health department and OMRI were involved in the process. I think you can say that people are comfortable with where the report landed. Are there people, including physicians, who may have different views, as health service providers or, indeed, the health department? There probably are, but I think the department generally is okay with where the report landed.

Hon TJORN SIBMA: That is important clarification to obtain from the minister. He is here in a representative capacity but he is also a minister with some skin in the game, obviously, in the best possible way. The reason I wanted to ensure to the largest degree possible that this represented at least a degree of comfort shared across government was that finding 4 of the report states —

> The Department finds that the requirement to obtain a determination from an independent medical practitioner in sections 110ZR and 110ZS of the *Guardianship and Administration Act 1990* (WA) is, on balance, an appropriate safeguard to protect incapacitated persons.

Members should bear in mind that once this bill passes, it will be subject to the same review clauses that pertain to the present act. The minister mentioned that the next review should be initiated in April next year, if I am right. Assumptions are a dangerous thing, but would it be a safe assumption that that position, that the definition and the IMP requirement in the foreseeable future, on balance will be an appropriate safeguard to protect incapacitated persons? Or might there be a view that emerges that perhaps not? What would potentially be the circumstances that that view, the setting of balance, the interpretation of what is in the best interests to protect incapacitated persons, might change? Who has the larger voice in that discussion at a departmental level? Would it be the Department of Health more broadly, particularly the OMRI group within that department, or would it be the Department of Justice? I am just trying to see who has the determining voice in these difficult discussions about the balancing of values.

Hon STEPHEN DAWSON: Ultimately, it is the Attorney General's act. The Department of Justice is responsible for the administration of the Guardianship and Administration Act. I cannot hypothesise as to where a future review might go. Like a parliamentary committee, it would consult widely with the various stakeholders. It would analyse the data and we will come up with recommendations. I cannot guess where it might go, but certainly the review is the responsibility of the Attorney General.

Hon TJORN SIBMA: Again, that is a very sound response in the circumstances. It would appear to me, with insight from the cheap seats, that this matter has arisen as reasonably contentious among some individuals or institutions within the broader medical research architecture and is possibly likely to remain so since there is no proposal from the government, and certainly not one we would move, that the IMP requirements be dispensed with, which is why the issue has been raised, and I will watch that space.

Can I get to another issue of contention that has appeared to materialise? It is more generally around administrative processes. The Department of Justice was dealing with the themes and arguments as they had been received. I think it actually endorsed the statement that administrative processes and forms are a burden for medical researchers. Is

it possible to shine more light on that? How many hours or how much lost time may be experienced when complying with safeguards on the enrolment of any individual candidate? I will talk to the ones who have a supported decision-maker working for them. Those are non-urgent matters. Are there any particularly egregious examples that might delay an enrolment—this becomes a bit subjective—for some unreasonable length of time, say, a matter of days or weeks, depending on the admission? I just want to try to understand the counterargument a little bit.

Hon STEPHEN DAWSON: Look, I imagine there are probably plenty of forms that physicians have to fill in across a range of areas in the health system. These are relatively new provisions. They have only been operational for a couple of years. It does take some time for new processes to be bedded down in agencies. On balance though, I think it is important that we do have a proper decision form relating to urgent medical research. I think where we are at the moment is appropriate.

Hon TJORN SIBMA: My train of thought was momentarily lost, but I have recovered it. Again, it is about the IMP matter. Maybe I will identify the Department of Health. Has the Department of Health recognised, at least, the challenge that some of its colleagues have identified with respect to the interpretation of the IMP requirement? Has the department, for example, drafted any policy or practical guidance to assist the interpretation of that? If it has, where might we find evidence?

Hon STEPHEN DAWSON: Yes, there is guidance available. There is a publicly available report called *Guidance document: Involving incapacitated adults in health and medical research*. It was put together by the Research and Innovation Office at the Department of Health in October 2020. The research governance service provides guidance and clarification, as well as a definition of what constitutes an IMP.

The Department of Health and the Office of Medical Research and Innovation will provide information to stakeholders through the research governance service website; updating the Department of Health's guidance documents and forms; meeting with health service provider directors of research; and through newsletters distributed by the Office of Medical Research and Innovation upon the changes in this bill coming to fruition.

Hon TJORN SIBMA: Was any finessing, nuancing or guidance provided to medical practitioners in the period of time after this report was finalised and our debate today? I raise this not to say "You have said on the report"; that is not what I am saying. I am saying that it seems to be a reasonably clear area of disgruntlement or concern. We can interpret that in different ways, but I acknowledge, as a non-practitioner, that there has been some trouble, at least with the interpretation of this. Has any update to guidance or advice been provided to practitioners over the course of the last 12 months that might provide them with a little bit more reassurance on how they should interpret and apply that principle? That is rather than waiting on little old me to bid farewell to this bill as it exits the chamber. Is there anything to nuance the discussion a bit more?

Hon STEPHEN DAWSON: The previously mentioned research governance service operates a helpdesk. If anyone has questions or issues, they can have their questions answered through that service.

Hon TJORN SIBMA: I am speaking from a position of curiosity—I am always loath to say ignorance, even though that might be the most honest description. However, it is a politically loaded self-descriptor, so I will ask out of the position of curiosity. Does that service desk, as I interpret it, operate 24 hours a day?

Hon STEPHEN DAWSON: No. It operates during business hours. However, there is an email. The service can be emailed and that is triaged and then answered by the staff in the service.

Hon TJORN SIBMA: Is there a pattern, portraying an origin of some kind, that the minister could assume from the presentation of an incapacitated candidate of how long it might take between their admission and enrolment in a program such as this? I want to put the urgent issues to one side because I think this case is of a different complexion. In non-urgent cases, what is the median time between admission and enrolment?

Hon STEPHEN DAWSON: I am told it varies according to the project. The shortest might be minutes, the longer ones take days. If the member has further questions on this area, I have a different adviser. After the break, I am happy to swap out if the member has a line of questioning in this area.

Hon TJORN SIBMA: I think it would assist the minister and the hardworking advisory staff to say yes. Certainly, I would like to understand that. If it is possible to provide or get answers that can get to whether or not there are trends that can be identified across different research streams—some can be more easily expedited and others take a longer time, or whether it is a case-by-case or location-specific metric—that would be useful. Minister, I might also —

The CHAIR: Order! Noting the time, I shall leave the chair until the ringing of the bells.

Sitting suspended from 6.00 to 7.00 pm

Hon TJORN SIBMA: I will ask just one question before taking a spell to let Hon Nick Goiran inquire into a number of matters. Seeing as we have had a change out in advisers, I thought it was appropriate. I was asking before about the potential median time between hospital admission and enrolment in a research program. Is the minister able to

provide any more detail around those sorts of dynamics? Particularly, I want to understand whether claims made by some medical researchers about how onerous this system is have any foundation.

Hon STEPHEN DAWSON: I do not have too much more to add. It can take minutes or hours, but it can take weeks or even indeed months in some cases, particularly for some of those community ones. In an emergency situation, they can be very quick.

Hon NICK GOIRAN: During consideration of clause 1 so far, there has been some important scrutiny of the safeguards, in particular whether the safeguard of an advance health directive is being enforced in practice, and also important questions about the safeguard that is the independent medical practitioner. I propose to ask a few follow-up questions in respect of these matters. Beginning with the independent medical practitioner, in the case of what is referred to as a "research candidate", or what I would describe as a patient, will an independent medical practitioner be used in both circumstances of urgent and non-urgent research?

Hon STEPHEN DAWSON: Yes.

Hon NICK GOIRAN: That is the case at the moment and will that continue to be the case once the bill passes?

Hon Stephen Dawson: That is correct, honourable member.

Hon NICK GOIRAN: That being so, has there been any instance in which an independent medical practitioner has refused to make a determination that a candidate is not likely to make a reasonable judgement?

Hon STEPHEN DAWSON: My advisers are not aware of any, but that does not mean it has not happened.

Hon NICK GOIRAN: Further to that, has there been any instance in which an independent medical practitioner has refused to make a determination that a candidate's participation in urgent medical research is in the best interest of the candidate or not adverse to their interests?

Hon STEPHEN DAWSON: It seems it is not recorded. We are aware of those that have been approved, but, according to my advisers, if it has been declined, that information is not provided.

Hon NICK GOIRAN: I think we ascertained previously that 220 research candidates were enrolled in these research projects up until the relevant date—I think it was towards the end of September, around the time of the delivery of the bill. Do we have any information on how many were sought to be enrolled but were not enrolled because of the independent medical practitioner safeguard?

Hon STEPHEN DAWSON: There is no requirement to report a decline. The usage of an IMP is reported. If it has been declined, that information is not collected.

Hon NICK GOIRAN: If a researcher wants to enrol a patient into a research program, they need to find an independent medical practitioner in order to comply with the scheme. Is the minister saying that in circumstances in which they cannot find the independent medical practitioner or the independent medical practitioner has refused, we simply do not have that data; it is not recorded anywhere?

Hon STEPHEN DAWSON: No, it is not collected. I am not sure whether the member's line of questioning is going to go around doctor shopping.

Hon Nick Goiran: That was going to be my next point. We won't know if that's not happening if this is not being reported.

Hon STEPHEN DAWSON: We do not. If the IMP said no, and the researcher went to somebody else, it is a small network so I think that information would get around and there would likely be a complaint to see whether somebody was trying to subvert the system.

Hon NICK GOIRAN: That leads to my next question. Have there been any complaints?

Hon STEPHEN DAWSON: I am told that there have not been any complaints so far. That is to the best of my knowledge.

Hon NICK GOIRAN: It is good that there have not been any complaints. I want to make a suggestion about the use of independent medical practitioners. This may be of benefit to those who will continue to have ongoing carriage of this scheme. We know that this scheme will continue to be monitored by the relevant agencies. Unless I am mistaken, the Department of Health, in particular through the Minister for Health, is required once a year to table data on research candidates. The minister indicated earlier that two such reports have been prepared, and a third report is due soon. When I say "soon", I mean within the next 12-month period, recognising that it will take some months before the report is published and provided. In addition to that mechanism, the Attorney General and the Department of Justice will continue to have some form of, shall I say, oversight, because they will need to provide a statutory review every three years from here on. As a consequence, multiple people from two agencies, as a minimum, will have ongoing carriage of this scheme.

It seems to me that it is important that from now on data is collected about approaches that are made to independent medical practitioners. If the data shows that an independent medical practitioner has been approached and has refused to support the application, that might alert the agencies to the possibility that the safeguard has been abused by people doctor shopping. If, on the other hand, we find after many years of data collection that every time an independent medical practitioner is utilised they approve the application, it might serve the other purpose of showing whether the safeguard is efficient. It might be effective, but if in the end it is just a rubberstamping exercise, or alternatively if the system is sufficiently robust that it no longer requires the use of an independent medical practitioner, along the lines of what Hon Tjorn Sibma asked prior to the dinner suspension, maybe at that point the safeguard could be removed. We will not know that if the data is not collected. I make that observation in the hope that those responsible for this system moving forward will give it some consideration.

We talked earlier about the fact that there have been 220 cases. Was an independent medical practitioner involved in all those 220 cases?

Hon STEPHEN DAWSON: I am told yes.

Hon NICK GOIRAN: Is that because all those 220 cases pertained to persons without capacity?

Hon STEPHEN DAWSON: Yes, honourable member.

Hon NICK GOIRAN: Recognising that it is almost certainly the case that more than one independent medical practitioner would have been involved across those 220 cases, those independent medical practitioners would have had to come to the conclusion and determination before they agreed to the application to enrol the person into a research program without their consent that that would not have an adverse outcome for that research candidate. Have there been any adverse outcomes?

Hon STEPHEN DAWSON: I am advised that of the 220 participants who are enrolled in research under part 9E of the Guardianship and Administration Act, one has experienced an unanticipated serious adverse event. The event may have been related to the use of a monitoring device, which was a requirement of the research project but would not usually be used as part of clinical care. It was noted that abnormally high blood pressure may have also played a part in this event.

Hon NICK GOIRAN: Obviously it is sad to hear that there has been a serious adverse event in one case, and so not in any way whatsoever to diminish the seriousness of that one incident, it is at least pleasing to note that there has been only one. That said, with respect to the one serious adverse event, what type of recourse is available to that person or any person who suffers an adverse event? Remember that this is a person, a Western Australian, who has been enrolled in medical research without their consent and an independent medical practitioner, who is a safeguard, has determined that their enrolment would not be adverse to that person. Notwithstanding that, a Western Australian has had an adverse outcome. What is the recourse that is available to them?

Hon STEPHEN DAWSON: There are two ways to complain. There is the ethics process and the governance process. The person or indeed their family member can complain to the ethics committee that was linked to the approval. The National Health and Medical Research Council has a national statement on ethical conduct in human research, which provides guidelines for researchers but also human research ethics committees and others conducting ethical review of research. It emphasises institutions' responsibility for the quality, safety and ethical acceptability of the research that they sponsor or permit to be carried out under their auspices. In line with the national statement, research projects are subject to review and monitoring by human research ethics committees, or HRECs, and the institutions conducting the project. This oversight begins before the project commences with the review and approval of each project by both an HREC and a research governance office, which is the review body acting on behalf of the institution. Oversight continues until the project is completed. As part of their responsibilities under the national statement, institutions through their research governance office and HRECs oversee research conduct throughout the project's lifetime.

Hon NICK GOIRAN: The minister is saying that there are two avenues or places in which a person can pursue some form of recourse. One is the ethics committee, which is the ethics committee that is overseeing the research project, and separate from that is the national body or national committee. A person can then complain to one of those two bodies, but what power do those bodies then have? I acknowledge that they might be able to improve the guidelines moving forward, maybe they might even be able to reprimand the person who was involved in the adverse outcome. I acknowledge that and I probably do not need any comment about that. I am more interested in hearing what kind of redress or remedy is available to the person who is, if you like, the victim of all of this—this is the person who has been subject to the adverse outcome. What satisfaction will they get out of going to an ethics committee or a national governance committee? Do those bodies, for example, have the capacity to distribute some form of compensation? Will they be able to extract an apology out of the people? That is the type of recourse that we are interested in getting to the bottom of.

Hon STEPHEN DAWSON: I want to clarify that although the statement is national, the governance is via state governance bodies and ethics committees. For recourse, there are a couple of things I could say. If an action was reported to the ethics committee, the study could be suspended totally and potentially discontinued as a result. The person could be reported to the Australian Health Practitioner Regulation Agency and they could potentially lose registration or whatever action AHPRA takes. They could potentially also sue for negligence in a court. They would be covered by insurance of the HSP—in many cases, that would be RiskCover or the commercial sponsor of the research.

Hon NICK GOIRAN: There are mechanisms in place that if a Western Australian is enrolled in medical research without their consent, pursuant to this scheme that involves the various safeguards, one of those safeguards is insurance. Interestingly, it was not commented on in the Standing Committee on Legislation's report. As Hon Dr Sally Talbot remarked last week, there was perhaps a little bit of dissatisfaction on our own part that we maybe did not get to the bottom of all these things. One of the things we did not get to was insurance. One of the safeguards here is insurance—albeit that it is not a safeguard to avoid an adverse outcome, but if an adverse outcome happens in the worst-case scenario. That is part of the regime in this scheme.

Hon Stephen Dawson: By interjection, that is correct, but, as the member quite correctly pointed out, it is after the fact.

Hon NICK GOIRAN: Yes. It is not what we want; nevertheless, we need to look after these people if it happens. In the case of the one serious event, did it involve the death of the patient? The minister is indicating that that was not the case. Was there some form of permanent disability? What type of outcome was it in that case? The minister said it was a serious outcome.

Hon STEPHEN DAWSON: I am told there were excellent outcomes and no further follow-up was required as a result of the treatment, so it was positive in that case.

Hon NICK GOIRAN: That is pleasing to hear, for the sake of the Western Australian involved. On the avenues for complaints, whether they be disciplinary or invoke any entitlement to put in a claim through the insurance process, is the research candidate informed in the event that they regain capacity or, alternatively, is their family informed? I say informed not just when an adverse outcome happens but as part of obtaining informed consent from the patient or the family member at a later stage.

Hon STEPHEN DAWSON: I am told that there is a patient information consent form provided to a patient—to a research candidate, which are the members words—that outlines a process. There is a requirement for health service providers to disclose this information to the patient and/or a family, too. That is a requirement.

Hon NICK GOIRAN: Are we confident that that has happened in the 220 cases?

Hon STEPHEN DAWSON: I am told it is just standard procedure and we are confident. There has only been that one case when there was an adverse reaction.

Hon NICK GOIRAN: Notwithstanding that, even though there has only been one adverse case, as part of the normal operating procedure there have been 220 of these forms and relevant information provided to the patient. Was consent obtained from the patient subsequently in all 220 cases?

Hon STEPHEN DAWSON: There is a requirement for the researchers to continue to seek that consent, I am presuming, but I am not aware whether there are any particular cases when consent was not received at the end of the day or down the track.

Hon NICK GOIRAN: I acknowledge that the minister is not aware, but is data kept about that? How confident can we be? It is a bit like the earlier question about forms and whether people are receiving information in advance about their right to put in a complaint. I accept that it is normal operating procedure. I also accept that it is part of this scheme. It is normally the case, in fact it is a mandatory requirement that consent be obtained, but I want to test whether we are enforcing this very important—I do not know whether we would call it a safeguard; I would describe it as a very important right—right to informed consent. There has been some form of emergency, an urgent situation, that has not enabled informed consent to be obtained, and that is why we then invoke this scheme involving an independent medical practitioner and substituted decision-makers, but ultimately we want to make sure. I think the minister on a number of occasions today, quite rightly, has drawn to our attention the purpose and the object of the very act we are seeking to amend. Whose interest are we most interested in? That of the vulnerable person. Yes, we all have an interest in medical research, but the desires of the medical researcher are very much secondary. Even the project and the points the minister has made about the need for funding and trying to remove some of those things are very important, but they are secondary to the right of the vulnerable person. Is data kept on how frequently consent is obtained after the fact?

Hon STEPHEN DAWSON: The researchers have to submit progress reports as part of the ethics and governance process. They would have to disclose, as part of that, whether consent had been provided. There must be an annual

report, but I am advised that ethics committees can take spot audits, so they can audit at any stage if there is any kind of issue. If there is not but a complaint is raised, it is mandatory for the health service providers to report the complaint to the Department of Health.

Hon NICK GOIRAN: I guess what the minister is saying is that at some point the patient or family member would be told and if they were not satisfied, they could always put in a complaint at that stage that it took too long before they were contacted or they were not told about this medical research. I accept that is some form of fallback position. Again, I will make this comment rather than ask a question: I think for those responsible for the scheme, once again we could improve the collection of data here by simply adding an extra colon to confirm that consent was obtained from a patient or substitute decision-maker. What would be even better—dare I say it; it would be gold-standard data collection—would be to provide data on how long, before the person started to get this medical research or, shall I say, treatment, and once they were part of this program, before consent was obtained by them or their substitute decision-maker. That would be useful, moving forward, as part of this scheme. At the very least, it would heighten in the mind of the practitioners involved in all of this that Parliament is saying that it is very, very important that they obtain that information at the very earliest possible opportunity. I accept that is what the regime requires of them at the moment; it is mandatory and they have to make their best endeavours to do so, but then having to report on it would ensure that would be done.

Hon Stephen Dawson: You make a very valid point. I am happy to take your suggestion away to see if I can fit it into the process, going forward.

Hon NICK GOIRAN: Thank you very much, minister. I acknowledge that in not only his representative capacity here today, but also his own capacity as Minister for Innovation; Medical Research and the like, he has a personal, keen interest in this. I thank the minister for that.

With regard to the advance health directives, the minister has already answered quite a number of important questions from Hon Tjorn Sibma earlier. I have one final question on this particular theme. Were there any instances when a person underwent or was enrolled in one of these medical research programs without their consent and it was later found they had an advance health directive saying that they should not have been resuscitated? I know there are circumstances when that happens from time to time. People have been resuscitated even though they have actually said they did not want to be resuscitated. That does actually happen. We can really feel for the paramedics and people involved in that type of emergency; sometimes they just have to act. There is no time to say, "I'll work it out now and make some inquiries into whether this person may or may not have an advance health directive and whether it may or may not say that the person should be resuscitated, because by the time I do all that, I have missed the opportunity to resuscitate them." I feel for those people who are involved in these genuine emergencies. Nevertheless, was there any such instance with regard to medical research?

Hon STEPHEN DAWSON: Not that we are aware of. I touched on WebPAS earlier. Under the WA clinical alert—MedAlert—policy, the existence of an advance health directive must be added to the Western Australian Department of Health patient administration system, or WebPAS. An inclusion as an alert on WebPAS will ensure that the presence of an AHD is flagged to the treating team upon admission to any WA Health site.

Hon NICK GOIRAN: Do we currently have a register for advance health directives in Western Australia? I know there was talk of developing one.

Hon STEPHEN DAWSON: I cannot be certain. I know that the first stage has been completed. I am not sure that the second stage has yet. The work is ongoing. If I can get any update while we are sitting here, I am happy to provide that to the member.

Hon NICK GOIRAN: For what it is worth, minister, I suspect that the register does not yet exist. I note that it was said that this would commence in late 2021 or early 2022, but we are now in the first quarter of 2023. I suspect that something like this would have received quite a bit of attention by all of us if it did exist.

Hon STEPHEN DAWSON: I was correct. Stage 1 was to develop a new AHD template. That has been completed. Stage 2 is to develop the actual register, and that work is happening now. There is a new form published by Health that can be uploaded to My Health Record, but the work is happening.

Hon Nick Goiran: Is there no scheduled date for a rollout at this stage?

Hon STEPHEN DAWSON: No, but I will see whether I can get that for the member.

Hon NICK GOIRAN: Thanks, minister. Again, I accept that these things take some time. I do not intend to pass any judgement on those preparing these things at the present time. All I can do is encourage them to continue to make best endeavours, because without the register, we are asking a lot of the medical practitioners, the researchers and so forth to sometimes, as I said earlier, in very urgent circumstances try to get on top of this. It is virtually mission impossible for people without a register. It is a very important step if we are going to adhere to the wishes

of people who have taken the time to manifest in writing these directives and what they wish to be done for them in health circumstances well in advance.

I think that the examination of clause 1 has been helpful for a range of reasons, not the least of which is just to test how strong the safeguards are in practice now, some three years into the scheme. As a person who has had grave concerns about how something like this might get misused, I am very pleased to say that the work that has been done—whether it was through the Standing Committee on Legislation, the Department of Health's annual reports or the Department of Justice's statutory review or the work of this Parliament, which is even now testing this—gives us a great deal of confidence that the system is working as it was intended. That is indeed very pleasing.

Moving forward, one of the few, if you like, oversight mechanisms that will be in place is the statutory review that will be required to be done by the Department of Justice. I have been very critical of the Attorney General on this. Members may be aware that there is a motion standing in my name on the notice paper of which I gave notice on 30 November last year expressing concern that the Attorney General had once again broken the law of our state, specifically with the breach of section 110ZZE of the Guardianship and Administration Act 1990. I do not propose to spend too much time unpacking all of that; I will simply say that it was a matter of law that the Attorney General was required to table in both houses of Parliament the statutory review on or before 7 April last year. That did not happen. As a statement of fact, that simply did not happen. I think the minister indicated earlier that it happened in February; I think it coincided with the introduction of this bill. By my calculation, that is more than 10 months after it was required by law.

Of course there is no penalty for a minister who chooses either inadvertently or wilfully to break the law of Western Australia on the tabling of a statutory review. There is no penalty for that other than perhaps having to listen to me make the point that the minister has broken the law or to have motions standing in a member's name that at a subsequent stage might be debated. None of that is satisfactory. The whole point of having a statutory review done in a timely fashion is to identify whether there are any problems in the system. As I said earlier, it is pleasing that this system appears to be working as intended so that the delay caused by the late tabling of the report has not had an adverse outcome for the operation of the scheme or for patients and research candidates.

However, I find it very interesting—this is more a comment than a question—that there has been criticism in the other place about the sunset clause, and this bill will go to the other place. Let us pause and think about that for a moment. If the Attorney General had tabled the review in April last year and introduced the bill, we would have been able to get rid of the sunset clause in April last year. The more than 10-month delay on the sunset clause was entirely caused by the Attorney General—nobody else can be blamed for it; it falls at his feet. I will leave it at that. It is not really a question, but moving forward I encourage whoever is responsible for these three-year rolling statutory reviews to make sure that they are done in a timely fashion, because there will be no other form of parliamentary oversight than us getting this very important tabled paper from a department independent of the Department of Health.

I know that during this debate at least one member of this place bristled at the fact that members who do not hold a medical degree feel that we can contribute on these matters. With the greatest respect to the honourable member who is away on parliamentary business, it is exactly because of that attitude that we need the oversight. Although I acknowledge the person's training, education, experience and expertise as a medical practitioner, I might add that, once upon a time, when I was practising law in Western Australia, I took on far too many medical negligence cases. Why did I take on those cases? I took them on because of errors made by these fallible human beings in Western Australia that we call doctors. Doctors do a fantastic job—thank goodness—but they are not infallible and sometimes they make mistakes. When they make mistakes, sadly, because of the conditions in which they work, these mistakes can result in the most adverse consequences, and that is why we need to have, as the minister outlined earlier, things like ethics committees, the national program that doctors sign up to, the state-based committee, insurance policies and the like, which are all very important. Minister, the point is this: in addition to all that, every three years, the Department of Justice, a standalone department that is separate from the Department of Health, will peer over the silo into Health and say, "What's going on with regard to the handling of this medical research on Western Australians without their consent?" I encourage those who are responsible for this to ensure that, in the future, these reports are tabled in a timely fashion. Having made those observations, I will turn to only two more topics; one is the use of placebos and the other is whether regulations have been used to exclude certain prescribed activities from the definition of "medical research". I will deal with the second matter first and then come back to the use of placebos.

An issue was taken up by the Standing Committee on Legislation. I think it was the only matter on which there was dissent, a lack unanimity, in the committee. Page 51 of the committee's report refers to section 3AA(3)(b) of the Guardianship and Administration Act 1990, which enables the government, through regulations, to prescribe that certain activities are not medical research. The majority of the committee found that that was an acceptable delegation of power. I was part of the minority of one of the committee —

Hon Stephen Dawson: It wouldn't be the first time, Nick, and I'm sure it won't be the last!

Hon NICK GOIRAN: Exactly right.

I said that it was not an appropriate delegation of legislative power. Today is not the time to have the debate about whether or not it is, the point is that that power currently exists. My question is: has it been used?

Hon STEPHEN DAWSON: I am told no.

Hon NICK GOIRAN: I move to the last theme that I want to take up this evening—that is, the use of placebos. Before I ask my question, I hasten to add that I have no objection to the use of placebos in medical research when a person has enrolled in that medical research and given their consent, because as part of that consent, that informed consent, they are told, "By the way, this research program involves the use of placebos so you might not actually get the thing that you think you're getting." They say, "Yes, I'm happy with that and to participate in this trial." I have no problem with that. My concern—I know that a number of members expressed this concern during the debate in 2020—is why we would allow for a scheme that uses placebos on people who do not have capacity. It seems difficult to fathom; what is the point of giving a placebo to a person who does not have capacity? Evidently, someone thinks that there is a point, because this has continued to be pursued for some time. I understand from the 2020 summary report provided to Parliament by the Department of Health—the second of the reports—that there were two cases of the administration of placebos or pharmaceuticals, which is the categorisation. Is the minister able to confirm whether it was placebo or pharmaceutical?

Just while the minister is taking advice, I might just add, for further clarification, that the two cases I was talking about were for urgent medical research. I accept that there were many other cases that were not urgent and were also codified as the administration of pharmaceuticals or placebo. It is the notion that in an urgent case, we might provide someone with a placebo, which is curious.

Hon STEPHEN DAWSON: I am told we do not know, honourable member. It is usually blind. The trial could be ongoing, which would be another reason why we would not be aware.

Hon NICK GOIRAN: To conclude on this point then, by way of comment rather than question, I again encourage those responsible for the ongoing administration of the scheme to continue to look at ways in which we can enhance the data collection to improve it so that it is as robust and useful as possible moving forward. In my view, there is benefit in expressly codifying the cases in which a placebo has been used. In any event, it is de-identified, so I do not see any problem with doing that. As I say, I think that would help the ongoing debate. In fact, I think it would help justify the views of those who continue to make the case "Yes, there is some great medical benefit and benefit to the community of Western Australia in administering a placebo to a Western Australian without their consent when they do not have capacity". There are evidently people who hold that view. I am yet to be persuaded on that. For the benefit of those people and their own argument, it would be good to codify this so that we can see the merits of it. As I said, I offer that by way of comment rather than question so that those who are continuing to improve the data might take it on board. I thank the minister for his indulgence.

Hon STEPHEN DAWSON: I know that was a comment. I take it on board. I just asked a question about whether the whole treatment team knows when a placebo has been used. I have been advised that no, they do not. If they were to know, it may well change how they treat a patient. I understand the member's point, but what I am told —

Hon Nick Goiran: Someone must know, obviously, for the purposes of the research.

Hon STEPHEN DAWSON: Somebody will know, but the whole treatment team would not necessarily know. It is an accepted scientific method to use placebos. However, I hear the point that the member has made.

Hon TJORN SIBMA: I am still on the safeguards thing —

Hon Stephen Dawson: Honourable member, sorry; say that again.

Hon TJORN SIBMA: I am still on the safeguards thing. We have spent some extensive time on the independent medical practitioner. I have a couple more questions on that and on the development or revision of forms. On page 31 of the review, there is a remark that captured my attention. It states —

> The requirement for an IMP to inform the research decision-maker or the researcher of the reasons for their determination (using the form) creates an audit trail and provides additional protections to an incapacitated medical research candidate.

I am attempting to ascertain when an audit of these decisions actually occurs other than in the regular-ish reporting to the minister. What is being audited and by whom?

Hon STEPHEN DAWSON: The forms go to the health service provider and then they go to the Research and Innovation Office at the Department of Health.

Hon TJORN SIBMA: Would it be a fair assumption that in the last three years since this bill has been in operation there has not been, for example, a spot audit check on whether or not the process has been complied with in respect of a particular case or a handful of cases?

Hon STEPHEN DAWSON: That audit would be likely to happen at the HSP level. I am told that the forms go to the director of clinical services at the HSP. That person might see discrepancies or issues with the form and at that stage would investigate whatever is wrong with the form or the inaccuracy.

Hon TJORN SIBMA: It is an assumption that the HSP has that capacity because they are effectively the vessel that contains the information. Are we aware of any HSP that has on its own initiative undertaken an audit?

Hon STEPHEN DAWSON: I am not sure. My advisers are not aware, but that is not to say that it does not happen.

Hon TJORN SIBMA: The sunset clause provisions were in themselves a precautionary mechanism when the bill was being dealt with in the way that it was being dealt with. We do not need to go over that ground. But obviously and quite rightly we have placed an emphasis on the importance of people, particularly vulnerable people, and their relationship and intersection with medical institutions and their enrolment in research. We have previously talked about a single adverse incident that was one of 220 subjects. That rate provides some measure of comfort. Nevertheless, we are not really in a position to determine, for example, whether the hierarchy when appointing a research decision-maker is followed or whether a lead researcher has discontinued medical research at the point at which a research candidate regains their capacity to consent. I think that underscores the point: an audit may have actually occurred but there is no reported audit outcome. We are assuming that the relevant HSP might undertake an audit, but has one been undertaken of the Department of Health's own volition yet? Might this be something that could be usefully done with either the Department of Health or the Department of Justice, or perhaps in coordination with some other agency as part of the next iteration of this report? Effectively, we have been asked to just assume, in the absence of evidence, that everything is being proceeded with properly, and I think that is a dangerous presumption. Would the state government have the capacity to direct an audit of that kind insofar as observations are made about whether procedures have been complied with in every particular case?

Hon STEPHEN DAWSON: An audit like that has not previously been undertaken. It could potentially be undertaken in the future. We could look at doing a random sample audit. That is probably something else we will take away from tonight to look at further. I make no promises, but it is something that we can look at.

Hon TJORN SIBMA: I thank the minister. I am quite genuinely encouraged by that reaction. I understand that it is not a firm commitment, but I think that it is perhaps a reasonable practice to initiate.

I have one final issue. I want to understand the relationship between the operations of independent medical practitioners and how they can be the signatory on these forms. Is an independent medical practitioner able to provide, say, endorsement by way of a teleconference or telehealth consultation? Is that possible or permitted under these arrangements or is that something that might be problematic?

Hon STEPHEN DAWSON: I think the question was whether telehealth could be used to provide IMP sign-off. It could potentially be used. I do not think that it is being used at the moment—certainly, my advisers tell me that—but there is nothing that expressly excludes it. Of course, having been involved in previous debates in this place about voluntary assisted dying, for example, there are federal telecommunication laws that prohibit telehealth advice being used for voluntary assisted dying. I do not know whether there are other things nationally that would preclude it. My advice is that there is nothing that we are aware of that would necessarily preclude it, but I am not aware of cases in which it has been used.

Hon TJORN SIBMA: Likewise, is there any prescription on the physical location of a medical professional serving as an IMP? Is their geographic location immaterial?

Hon STEPHEN DAWSON: That is correct.

Hon TJORN SIBMA: Beyond the functioning of the IMP, I have other follow-up questions on telehealth. I think this was addressed in some form in the standing committee report. A reasonable argument is made that people in rural and regional Western Australia are disadvantaged to some degree by the practical operation of the current act. Is that a view shared by government, and what else might be done to, I suppose, improve equity among a cohort of incapacitated people who reside outside the metropolitan area?

Hon STEPHEN DAWSON: Could people in regional Western Australia be worse off? Potentially. I will bring to the attention of the chamber an initiative by the WA Country Health Service; it has a command centre located in the city centre. Clinicians and practitioners from around the state have access to the best and brightest medicos at the end of a phone or, indeed, on screen. I have had the opportunity to go down and visit. Wherever someone is in regional Western Australia, they can link into the command centre and get the latest advice. Sometimes, people in the regions have better access to clinicians than people might have in the metropolitan area because those people are there ready and waiting, and they are available regardless of where someone is. Things like that could potentially be used to make IMPs more accessible, I guess.

Clause put and passed.

Clauses 2 and 3 put and passed.

Clause 4: Section 110ZO amended —

Hon TJORN SIBMA: This is the part of this very slim and elegant bill that deals with —

Hon Stephen Dawson: I love a slim and elegant bill!

Hon TJORN SIBMA: It is nice to have some aspirations at this time of the evening. It is an aspiration that I struggle with on both fronts, I have to say!

This clause introduces the second of the two substantive limbs. We have covered in almost excruciating detail the issues around sunset clauses and the like, but from a position of equity and an appreciation of the complexities and realities around allied health professions and the like, this clause will broaden or redefine "registered health practitioner" away from its tighter description as a medical practitioner in an exclusive sense to encompass a range of 16 health professions contained within schedule 1 of the Health Practitioner Regulation National Law (WA). It is quite an extensive list. I must say, there are a number of professions—I will not call them sub-professions; I will call them professions—that would not automatically leap out to me, as a layperson, as the sort of medical professions we would expect an incapacitated person to be enrolled with. Perhaps I might ask very succinctly whether this was the best alternative for broadening the definition of "registered health practitioner" beyond its more prescriptive and narrow medical practitioner description, or whether the government had an alternative list that it could possibly have reflected on and utilised in this bill.

Hon STEPHEN DAWSON: I am told we got legal advice to suggest that this was the best way forward. In other states a similar definition is used.

Hon TJORN SIBMA: At the risk of complicating things, did the advice indicate whether one or perhaps a few of those professions could have been excluded from contemplation for the purposes of the operation of this legislation?

Hon STEPHEN DAWSON: I think it is important to say that anyone on this list would not be a lead researcher unless the research is pertinent to their practice. I am not sure whether the member is pointing out, for example, whether Chinese medicine or chiropractic therapy is in there, but certainly all these things are oversighted by the Australian Health Practitioner Regulation Agency. AHPRA has the ability to sanction registered health professionals for professional misconduct or unprofessional misconduct under the Health Practitioner Regulation National Law (WA) Act 2010, which can include an offence under another health statute, such as the Guardianship and Administration Act 1990. AHPRA can also make decisions on a health professional's continuing registration, such as imposing conditions or training on the individual if it has been satisfied that there has been unsatisfactory performance. The Guardianship and Administration Amendment (Medical Research) Bill 2023 specifically refers to the definition of "registered health practitioner" that is contained in the Health Practitioner Regulation National Law (WA) Act 2010, rather than the broader health practitioner definition, to ensure that the intention of the final report's recommendation is met. That obviously came out of the final report by the Department of Justice.

Hon TJORN SIBMA: My interest was not so much with the inclusion of Chinese medicine; frankly, I could anticipate that for some cultural reasons, but I found the inclusion of chiropractors and midwifery of an incapacitated person an interesting concept to deal with. That is not to say that that has not happened, but I would find it quite unusual, and I would say that about optometry as well. That said, I imagine that the bulk of the research task that would involve health professionals such as these, particularly in the emergency space, is of particular relevance to profession (ja) in the explanatory memorandum, paramedicine; and, in terms of the delivery of programs in the community, profession (a), Aboriginal and Torres Strait Islander health practice, is also particularly relevant. As my last question on this, I request some advice on which of these professions are expected to be represented, or more frequently represented, post the passage of this bill. Does the minister anticipate new research streams being enabled as a consequence?

Hon STEPHEN DAWSON: I am told that the professions that are most likely to be involved are medical, nursing, paramedicine and physiotherapy. Just because there are 16 different professions on this list, it does not necessarily mean that they will, in fact, be lead researchers moving forward. There is that ability but, of course, like everything else, the research project needs to go through an ethics process, and during that process I guess they would decide who is most appropriate or, indeed, who is not appropriate to be a lead researcher for the proposed research to be undertaken.

Clause put and passed.

Clauses 5 to 7 put and passed.

Clause 8: Section 15 deleted —

Hon TJORN SIBMA: This is perhaps more of an observation than a question on the final clause of the bill. This clause will delete the transitional provision arrangements that were a feature of the 2020 iteration to protect the integrity of research programs initiated prior to the then feared onset of the sunset clause. That is my understanding—or am I confused?

Hon STEPHEN DAWSON: The member is correct.

Clause put and passed.

Title put and passed.

Report

Bill reported, without amendment, and the report adopted.

Third Reading

Bill read a third time, on motion by **Hon Stephen Dawson (Minister for Emergency Services)** on behalf of the Parliamentary Secretary to the Attorney General, and transmitted to the Assembly.